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ABSTRACT

Presented is Michigan's plan for improving services to the developmentally disabled who are institutionalized or at risk for unnecessary institutionalization. Such planning principles as accountability and normalization are said to be the basis for recommendations at the state, regional, and local levels, as well as for state home and training schools. Reviewed are procedures and methods of plan development. Reported are project findings regarding state home and training schools (including incidence figures for secondary handicaps and habilitative program descriptions) and community programs and services (including the need for a central referral service and home counseling). Position papers on educational programs for residential placements, nursing homes, prevention, nutrition, and dental services are provided. Diagramed is a proposed organization system. Outlined is agency and service delivery model information for infants, preschoolers, children, adolescents, young adults, adults, and the elderly. Among the four appendixes are sample surveys and workshop programs. (CL)

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A PLAN FOR IMPROVED SERVICES FOR THE DEVELOPMENTALLY DISABLED IN MICHIGAN

JUNE, 1974

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A PLAN FOR IMPROVED SERVICES FOR THE DEVELOPMENTALLY DISABLED IN MICHIGAN

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ACKNOWLEDGMENTS

This state planning document has been developed with the assistance of persons throughout the State of Michigan. The Project staff made complete use of planning bodies, agencies and individuals in Michigan, to assist in developing a practical plan to meet the needs of the developmentally disabled during the coming years. The cost of this Project in terms of people's time and efforts, would be incalcuable.

We were extremely fortunate on the Project staff to have the most capable assistance of Mrs. Sharon K. Miller, M.S.W., who was responsible for the institution phase of the Project. Her alert mind took her beyond the institution phase and into all facets of the Project planning effort. Mrs. Miller deserves much credit for her dedicated and intense efforts to develop an outstanding State Plan.

Assisting Mrs. Miller was Mrs. Virginia White, an Occupational Therapist who was highly respected and skilled. Mrs. White was involved in the institution phase of the Project. Mr. Michael Kreider served as a consultant who was responsible for the visit to the Newberry State Hospital and prepared an excellent report regarding his visit to that facility.

The secretarial assistance throughout the Project of Mrs. Elaine McAllister has been greatly appreciated. She has provided outstanding services to all of the persons connected with the Project.

This Project was done by contract on the part of the Michigan Department of Public Health with the Michigan Association for Retarded Children and Adults. Mr. Harvey Zuckerberg, the executive director, has been totally supportive and helpful throughout the Project. Mr. Zuckerberg provided consistent assistance to us in responding to the critical issues as needed throughout the Project. The MARCA Staff also provided cooperation and assistance to the Project.

The Michigan Interagency Cadre was the primary advisory group for the Project. They assisted greatly, as did the agency heads of the various departments in responding to the issues and developing a practical state

plan. The agency cooperation was outstanding. Mr. Joseph McCall, of the Information Office of the Michigan Department of Mental Health deserves special thanks for his efforts to supply all requested information.

The information regarding the institutional needs was obtained by direct visits to each of the state institutions for the retarded. The superintendents and their staffs were exemplary in their assistance to the Project, and we owe them many thanks. The "community needs survey" was accomplished through the Regional Interagency Coordinating Committees for the Developmentally Disabled. We received an astonishing 100% response to the surveys. In addition, the responses were meaningful and extremely well done, showing a strength on the part of the regional interagency system in this State.

There are many others who have assisted us throughout this Project. Our sincere thanks to all who were involved in this effort.

Gail A. Harris, Ed.D.
Project Director

INTRODUCTION AND PURPOSE

Every state was given the opportunity of conducting a project of "national significance" whose purpose was clearly spelled out by the national government. The Michigan Department of Public Health applied for this project to be operated by sub-contract with the Michigan Association for Retarded Children and Adults. The completed project report is being submitted to the Michigan Department of Public Health for appropriate processing.

The national label for the Project was "Institution Reform and De-Institutionalization Plan." We have chosen to call it "A Plan for Improved Services for the Developmentally Disabled in Michigan."

The developmentally disabled are those who have a disability attributable to mental retardation, cerebral palsy, epilepsy or other neurological handicapping condition of an individual found to be closely related to mental retardation or to require treatment similar to that required by mentally retarded individuals, and

..the disability originates before such individual attains age 18
..and has continued, or can be expected to continue, indefinitely
..and constitutes a substantial handicap of such individuals.

The purpose of this plan is to help meet the needs of developmentally disabled persons of all ages who are currently in inappropriate institutional settings or at risk of being unnecessarily institutionalized. The specific aims of this Project were:

1) To survey service gaps in communities and institutions.
2) To delineate responsibility for each type of service.
3) To develop a plan of action to provide such services, with cooperative roles of state departments and communities spelled out.

PLANNING PRINCIPLES

The recommendations in the following section are based on these principles:

1. There should be an identifiable placement of responsibility, accountability and coordination for the delivery of services to the developmentally disabled.
2. Comprehensive services for the developmentally disabled requires effective inter-agency (as well as inter-disciplinary) communication, coordination, planning and evaluation at all levels (state, regional, local) of operation.
3. Generic community services should be available to the developmentally disabled, with additional specialized services provided where the generic service is not appropriate or sufficient to reduce disabilities to the ultimate degree feasible.
4. Programs and services for this group (retarded, cerebral palsied and epileptic) should be based on the "normalization" principle; that is: allowing them to obtain an existence as close to the normal as possible. For example, normalization means:

   a normal rhythm of day

   a normal routine of life, with a program outside of the home,

   a normal rhythm of the year, with a vacation,

   an opportunity to have normal developmental experiences at various life stages,

   an opportunity to make choices and to take risks,

   living in a bisexual world,

   having economic security, and

   having normal locations and sizes of physical facilities.

5. The developmentally disabled should have the same basic civil, legal and special rights and responsibilities as normal citizens, such as the right to an appropriate education and the right to non-discrimination in housing.
6. There should be a fixed point of referral and coordination where specialized services are provided. Each regional area should have a plan to have services available within a reasonable geographical distance from the home of the individual to be served.

7. Specialized provisions should be based on carefully developed individual service plans appropriate to age and disability level.

8. The components (i.e., staffing, planning and treatment) of specialized provisions should be of the highest quality.

9. Services for the developmentally disabled should include consideration of the total well-being of the family-unit, including the need for respite care provisions, crisis intervention and very early basic counseling.

10. Program and service changes should be based on the principle of achieving improved services for the individual for his maximum habilitation and movement within a continuum of care arrangement of services.

11. High priority should be given to programs and services designed for the prevention of developmental disabilities.

12. Assistance for local program development should be available not only from state agencies but also through other local programs which have been given a special charge to provide practical, technical assistance for specific purposes.

RECOMMENDATIONS

Key recommendations follow, with additional specific recommendations included in other sections of the document, such as in Position Statements and Coordination.

Many of the recommendations will require additional funding. Since serving the developmentally disabled requires state leadership and accountability, it is recommended that funds be appropriated by the state legislature to meet these needs wherever possible. Federal grants should be sought more in the area of short-term projects. The budget priorities of each agency should reflect these recommendations of changes which are necessary to meet the needs of the developmentally disabled in Michigan.

Selected Recommendations and Plan of Action

Following each recommendation is a suggested date for implementation efforts to be initiated.

I. Recommendations Requiring Interagency Action to Close Identified Service Gaps in Planning and Coordination.

A. State Level

1. The role of the Developmental Disabilities Advisory Council should be re-defined in terms of their need to set goals, establish policy and evaluate progress. (September, 1974)
2. A new full-time position of Policy Coordinator for developmental disabilities should be concerned with policy development, coordination, planning and evaluation and should be directly responsible to the director of the agency. (September, 1974)
3. Cadre members (from the Departments of Education, Vocational Rehabilitation, Mental Health, Public Health and Social Services) should function as described in the Coordination Section of this document.

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The heads of the agencies represented by the Cadre should re-affirm their support of inter-agency functioning.

The composition of the Cadre should be reviewed in terms of including members whose roles have key emphasis on mental retardation and specifically related disabilities. Cadre members should have a commitment to this functioning, be creative in dealing with state planning issues, and be task completion oriented.

A consultant from the Office of Management and Budget should participate in Cadre meetings on request when budget issues are discussed. (August, 1974)

4. A "primary planner" role should be assigned to specific Cadre members on the basis of primary life stage needs. (Refer to Coordination Section.) (September, 1974)
5. Action should be taken to provide mandatory accountability for the provision of program services to those developmentally disabled persons over 25 years of age who are unable to participate in competitive employment. Community Mental Health Boards should become, by statute, the accountable agency. (November, 1974)
6. Intensive inter-agency in-service education efforts for all service providers should be developed. All possible resources, including universities, should be utilized in this effort. Included should be topics related to:

   Inter-agency budgeting,
   Planning action research,
   Health Services - Nutrition, Dental Care, Epilepsy, etc.
   Evaluation Procedures,
   Inter-agency case services

   (September, 1974)

7. Intensive statewide service inter-disciplinary in-service education centers for practical technical information should be provided. Suggested is:

   Oakland CMH - "MR Services through Community Mental Health"

   Oakdale Center - "Residential Services"

   ---Special funding would be required

   (July, 1974)

8. Efforts should be made to implement the recommendations in the Community Placement study completed by the Michigan Office of Health and Medical Affairs. (July, 1974)

9. The Division of Vocational Rehabilitation should develop a clear procedure for the Department of Social Services licensed group home operators. The referral procedure should be specifically for evaluation of physically impaired developmentally disabled who might qualify for the Homebound Craft program, or other programs that may be developed for the severely handicapped population. (December, 1974)

10. The Departments of Social Services and Public Health should take the leadership in addressing the problems of poverty which increase the risks of mental retardation including nutrition, pre-natal care and Lead-Based Paint information. Current retardation specialists could survey the scope of needed activities.

    Provisions should be made for nutrition instruction to be included in programs serving the developmentally disabled. (December, 1974)

B. Regional Level

1. The 19 regional inter-agency areas should be reviewed in terms of the appropriateness of their boundaries, with revisions suggested. The committees themselves should suggest changes. They should consider the possibility of changing to the "State Planning and Development Regions" so that voluntary cooperation in regard to other areas of planning community services can occur. (January, 1975)

2. Regional inter-agency committees in the state should be given upon request and after cooperative planning with the Cadre, state and federal monies to support a full-time professional coordinator and secretary to be housed in one of the existing regional agencies, and to report to the state office. The role would be specifically defined and would be assisted by intense training efforts by the state inter-agency team. Basically, the RICC's would be responsible for assessment of needs, planning, inter-agency coordination of services, case appeal reviews and evaluation. (Note Coordination Section.) (September, 1974)

C. Local Level

1. Life consultation (an individual plan for a continuum of programs and services) and referral centers with follow-along services to serve the developmentally disabled should be developed within reasonable geographical distances. It is recommended that Community Mental Health Boards assume major responsibility for this, with the Intermediate School District assuming prime service responsibility for the 0-25 year old group and CMH Boards being similarly accountable for those over 25 years. This would include institution residents. (September, 1974)
2. The developmentally disabled should be served locally by inter-agency teams, with a team leader assigned from the prime service agency at the specific stage in his life. The team leader would carry primary responsibility for supplying information to the follow-along service agency and requesting appropriate services from the other agencies. (September, 1974)

II. Areas Requiring Additional State Study and Plan of Action.

A. The need for a specialized service with diagnostic and treatment components for severe epileptic patients should be immediately researched in-depth by the Michigan Department of Mental Health and the Michigan Department of Public Health. It should include

specific information about persons in need of the service and potential tie-in with other state resources. The numbers in need of intense services should be concretely determined. This should compliment the feasibility study in Wayne County which is being conducted by the Epilepsy Center of Michigan. (September, 1974)

B. The D.D. Advisory Council should arrange for an in-depth review of the Michigan Housing Authority special provisions for housing for the retarded. (November, 1974)

C. The possibility of the institution dollar following the individual during the first year of community placement should be explored by the Advisory Council on Developmental Disabilities. (September, 1974)

D. A specific inter-departmental agreement should be reached to provide transportation to daily programs. Legislative changes may need to be made to allow school bus transportation to daily programs for the adult developmentally disabled. (August, 1974)

III. Legislative Action Required.

A. Consumer agencies and appropriate state agencies should push legislatively for non-discriminatory zoning laws for the developmentally disabled. (October, 1974)

B. Additional daily program and service funding should be requested by the appropriate agency for immediate needed services for the following:

Education programs-4,000 institution residents -	$13,418,200
Day Training programs-Released Residents - (Total of 2,751 pupils)	$ 9,604,295
Adult Activity & Sheltered Workshops-plus 3,588 persons -	$10,000,000
Total Additional Funds	$33,022,495

(Immediate)

C. Additional funds are needed for state mentally retarded institutions to meet national accreditation standards. Urgently needed are improved health care services especially. (Including physical restoration, dental care, vision and hearing evaluation and restoration, etc.) (Immediate)

D. Continued operational monies are required at an adequate level. (Immediate)

IV. Individual State Agency Action Required.

A. The Michigan Department of Public Health should continue to spear-head intensive state efforts in the area of Prevention. This would include public information and action programs about lead-poisoning, pre-natal care, genetic research, infantile spasms, etc. (On-going)

B. It is recommended that the State Department of Education expand current home training services to specifically include assessment of the family unit's needs for supportive services. Current ancillary professionals could perform this function with directed referral to existing community services in those situations requiring on-going intervention. (September, 1974)

C. Additions should be made to the data system currently being developed by the Department of Scoial Services for tabulating numbers of developmentally disabled being served. Of particular importance to inter-agency functioning are numbers of adults and children in foster care and numbers receiving medical financial assistance. (Immediate)

D. It is recommended that each state agency provide a Developmental Disabled Specialist (with academic and experience background in mental retardation) in each departmental regional office with responsibility for in-service education of generic staff. Current staff could assume this. (September, 1974)

E. The Department of Education and its local counterparts should assume full responsibility for educational programs for all individuals from 0-25 years irrespective of home placement. (Including those in nursing homes and institutions.) (Immediate)

F. Additional state consultants should be immediately employed to develop in-service education programs. (Immediate)

Agency	
Education	Institution-Education and Treatment Programs
Mental Health	Mentally Retarded Nursing Homes
Mental Health	Mentally Retarded Institution and Community Services Programs
Social Services Vocational Rehabilitation	Residential Home Services (Group Homes) Service to the Severely developmentally disabled.

V. Evaluation Efforts.

A. Written regional and state plans should include specific measureable goals. (December, 1974)

B. The Developmental Disabilities Advisory Council and the Cadre should spear-head evaluation efforts. (January, 1975)

State Home and Training Schools Recommendations

1. It is recommended that the unit system of case management be fully implemented to provide a greater pinpointing of responsibility for coordinated service delivery within institutions. (Implementation by: October, 1975)
2. It is recommended that the Michigan DMH/MR - Functional Behavior Profile continue to be implemented and revised. Utilization of it as a tool to plan and evaluate specific training efforts should be clearly emphasized at the service delivery level. (Implementation: On-going)
3. An accountable formal system should be developed for family input into individualized program planning as well as overall policy development. (A model for such a system could be that developed from P.A. 198.) (Implementation: On-going)
4. The gap between identified numbers of secondarily impaired children and remedial equipment supplied should be immediately addressed, i.e., numbers of hearing aids, eye glasses, etc. Staff trained to appropriately screen and program for these secondary

handicap areas should be hired in at least the ratios consistent with the 1964 AAMD standards. (It is recommended that Mental Health apply for one of the proposed ten national implementation grants of $100,000 for this specific purpose). (Implementation by: July, 1975)

5. Health screening and maintenance services for institution residents should be immediately upgraded by greater utilization of existing services provided by the State and County Health Departments. (Implementation: On-going)
6. Written individual program plans should be completed for all residents in all programs in conformance with National Accreditation standards. Program plans should be available on the wards for daily utilization of the direct-care staff. (Implementation by: July, 1975)
7. Special attention should be given to the programming needs of the Adult (age 18+) residents which comprise over 70% of the institutional population. Two vital parts of this effort should be:
   a) Community liaison by the institution directed at acquiring senior citizen programs and service benefits for those residents approaching their elderly years. (Implementation by: July, 1975)
   b) Institution cooperation, with the proposed accountable Community Mental Health Agency, to assure each eligible person (particularly the young adults 18-25) appropriate community based Adult Activity Centers or Sheltered Workshop programs. (Implementation by: July, 1975)
8. The Division of Vocational Rehabilitation should be involved in pre-release planning. The DMH should request District DVR offices to immediately assess the number of institution residents who may qualify for services. (Special consideration should be given to the new DVR emphasis on the severely disabled.) After assessing the need, a specific plan to provide appropriate services should be developed by DVR in cooperation with appropriate others and presented to the Cadre for follow-through. (Implementation by: September, 1975)

9. Guidelines for community placements should be developed and standardized for all State Home and Training Schools (Deniston's Rule 234 is suggested as a model - See Appendix C, page 31). (Implementation by: January, 1975)

10. Pre-release planning has been emphasized in clear policy statements issued by the Michigan Department of Mental Health Central Office. It is recommended that the State departmental policies be translated into more specific components including:

    a) Provision of a graded sequence of community experiences on a regular basis prior to release (preferably beginning at the time of entry to the institution). These experiences should be for teaching and practice of skills (crossing streets, eating in restaurants, shopping, etc.) vital to successful community living. (Implementation by: January, 1975)

    b) Staff assignments should be made consistent with the pre-release planning philosophy. (Implementation: On-going) Examples are:

        1. Sending ancillary professional specialists out into the community with individual residents to provide more "on the spot" evaluation of community readiness skills.

        2. Greater involvement of community placement staff in residential programming to facilitate the match between residential training efforts and the skills required in the setting to which the resident will move.

    c) Requirements that the initial program plan reflect agreements between the referring agency, client/family and agency personnel regarding the purpose of institutionalization; i.e., what is to be specifically accomplished, in terms of training, by the admission. (Implementation: On-going)

d) Requirements that documentation be provided prior to release (to all original participating roles) that the presenting problem has been addressed and the degree to which intervention efforts have been successful or have failed. (Implementation: On-going)

11. The Department of Mental Health should develop standard release information forms. All changed residential placements should go through the Community Mental Health Office (in its Life Consultation function.) (Implementation by: July, 1975)

12. The Michigan Department of Mental Health should provide leadership to have each State Home and Training School develop an advisory board including consumer and university representation. (Implementation by: July, 1975)

*It should be noted that the State Department of Mental Health does not support this recommendation.

13. The Department of Mental Health should arrange for institutions to use all available resources to serve the residents. E.g., The Serum Lab of the Epilepsy Center of Michigan should also be used to test anti-convulsant levels of persons in residential facilities. (Implementation by: January, 1975)

14. Leadership should be provided by the State Department of Mental Health in implementing the in-service training needs identified in the Project Survey. Of particular need for Central Office leadership are those training needs related to inter-agency workings at the service delivery level, and interdisciplinary therapy procedures utilized for deinstitutionalization and/or maintenance of community placement. (Implementation: On-going)

15. The role of the institution as a back-up resource to community services should be reflected in the provision of quality respite care, short-term intensive behavior modification and training programs and diagnostic/evaluative services. (Implementation: On-going)

PROCEDURE AND METHODS OF DEVELOPING PLAN

The procedures utilized in developing the State Plan included:

a) Review of materials

b) Consultations and information sharing

c) Surveys

d) Program visits

e) State inter-agency conference workshop sessions

The committee received excellent cooperation from all of the State Offices and other individuals and agencies contacted during the Project. The State Offices in particular opened up all of their records so that we could review the information and gain background knowledge to assist us in developing this State Plan.

The materials reviewed included:

Mental Health records, budgets, informational materials and newsletters:

State Auditor General reports:

Study of Community Placements by Office of Health and Medical Affairs:

Social Services Studies:

Reports of public hearings from Department of Social Services and Mental Health:

Applications for Developmental Disabilities Grants;

Proposed Mental Health Statutes;

United Cerebral Study of Adult CP's;

Institution Communications;

Reports of Special Projects:

MARCA Records and Reports of consumer visits to Institutions; and

Recommendations from Inter-Agency Workshop Held February 7-8, 1974.

There was a wide range of consultations and information sharing for Project purposes. The State Inter-agency Cadre was a key advisory group throughout the Project. In addition, we consulted with the following agencies and individuals:

Michigan Association for Retarded Children and Adults

--Staff and Board of Directors
--Residential Services Committee
--Social Services Committee
--Parents of children at each institution

Michigan United Cerebral Palsy Association

--Mr. Roy Morrison
--Mr. Robert Mayberry

Detroit United Cerebral Palsy Association

--Mr. James Simpson

Office of Services to the Aging

--Ms. Mary Milan

Michigan State University Cerebral Palsy Clinic

Epilepsy Center of Michigan

--Mr. Thomas Caughlin
--Dr. Phillip Rennick

Institute for the Study of Mental Retardation and Related Disabilities

--Dr. William Cruickshank
--Dr. Julius Cohen
--Dr. Kevin Lynch
--Dr. Larry Turtan

Michigan Department of Mental Health

--Dr. Gordon Yudashkin
--Advisory Council
--Miss Evelyn Provitt
--Dr. David Ethridge
--Mr. Robert Drews
--Mr. Joseph McCall
--Mr. John Reynolds
--Dr. Joseph Denniston
--Dr. Robert Trenz
--Mr. Robert DeVoe
--Mrs. Kay Kaye
--All Mental Retardation Institution Superintendents

Michigan Department of Social Services

--Mr. R. Bernard Houston
--Mr. Thomas Cook
--Mrs. Rita Charron
--Ms. Jane Swanson
--Mr. John Johnson

Michigan Division of Special Education

--Mr. Murray Batten
--Dr. Mary Blair
--Miss Dolores Fowlkes
--Mr. Fred Chappel
--Mr. Tom Howard
--Mrs. Jane Walline

Michigan Division of Vocational Rehabilitation

--Dr. Donald Galvan
--Mr. Harry Smith
--Mr. Richard Carlson

Michigan Department of Public Health

--Dr. Maurice Reizen
--Dr. Thomas Kirk
--Mr. Paul Tobey
--Mr. Joe Johnston
--Mr. Lonnie Johnson
--Dr. Howard Mehaffey
--Ms. Marie Weber
--Ms. Molly Graber
--Mr. Edmund Radke
--Mr. David Katt
--Mr. Robert Shipman
--Advisory Council on Developmental Disabilities

Michigan State University

--Dr. Hugh McBride

Michigan Auditor General's Office

--Mr. Richard Krieger

Michigan Association of Administrators of Special Education

--Mr. Tracy Stockman

Michigan Association of Intermediate Special Education Administrators

--Mr. Fred Knowland

Wayne County Referral Center

--Mr. Greg Owens

Michigan Nurses Association

--Mrs. Joan Guy
--Mrs. Ann Zuzich

Senate Fiscal Agency

--Mr. Lou Bozak

House Fiscal Agency

--Mr. Vic Weipert

Representative Joe Snyder and other representatives involved in workshop

Senators involved in workshop

Governor's Principal Health Advisor

--Dr. Donald C. Smith

Michigan State Employees Association

--Mr. John Doyle
--Mr. Ed Bucko

Office of Management and Budget

--Mr. Bob Gleis
--Dr. Gerald Miller
--Dr. John Dempsey

Education - Mental Health Committee on Institution - Education Programs

Surveys - There were three project surveys (see Appendix A):

Survey for MR Institutions (pp. 126-136)

Survey for Regional Inter-Agency Coordinating Committees for the Developmentally Disabled (pp. 137-141)

Survey for Adult Activity Centers (p. 142)

The institutuon survey, developed by the Project staff, was a five part survey which was completed during a personal interview with the persons involved including institution administration, nursing personnel, program personnel and attendant nurses. The purpose of the survey was to determine what broad recommendations should be made for the improvement of programs and services within state institutions for the retarded so that they could be directed toward meeting the standards established by the Joint Accreditation Commission. Several institutions were already involved in a self survey preliminary to requesting a visit from the national accreditation team.

The 19 Regional Inter-agency Coordinating Committees each received a survey after the chairmen agreed to participate in this Project. The survey asked two questions:

1) What specific or additional changed services are needed to prevent unnecessary institutionalization of the developmentally disabled? and

2) What specific additional or changed services are needed to help make the return of institution residents to community life successful?

The regional inter-agency survey form suggested a response format and provided some background consideration suggestions. One hundred percent of the nineteen regional inter-agency committees responded to this survey.

An finally, because a major need in the state appeared to be in the area of programming for the adult retarded, a survey was mailed to the current adult activity centers to determine the number of placements available, and the known numbers on the waiting list for such services.

The Michigan Association for Retarded Children and Adults - Social Services Committee submitted a statewide survey to local associations for the retarded, asking about known numbers of the retarded waiting for programs or services.

Visits

Visits were made to each of the state institutions for the retarded, to the MSU Cerebral Palsy Clinic, to the Kent County Life Consultation Center, to several community residential facilities, to Community Mental Health Boards and to sheltered workshops.

The Cadre members visited several of the Regional Interagency Coordinating Committees. The Project staff visited the Regional Interagency Coordinating Committee in the Upper Peninsula.

State Interagency Workshop

The Project staff developed twenty workshop sessions at a State Conference on March 11, 1974 to make specific recommendations regarding community placement needs and other needs of the developmentally disabled to assist in the State planning efforts (see Appendix B, pp. 144-147). About 500 inter-disciplinary participants were involved in the Conference and made specific recommendations which are included in this document.

The State Interagency Cadre members participated in the refinement of the recommendations suggested by the Project staff after reviewing the materials received from the surveys and other sources. The Cadre members provided background information to the agency heads, who met on May 16, 1974 as a group to discuss the recommendations and their own agency commitments to action (see Appendix D, pp. 157-159).

Thus, this Plan has been developed as a result of extensive involvement on an interagency basis of all parties concerned throughout the State. In addition, agency heads have had input to the recommendations, and an opportunity to revise and add to the State Plan.

PROJECT FINDINGS

The project emphasized the determination of service needs for those developmentally disabled individuals in institutions or in communities at risk of being institutionalized.

Table 1 indicates the current and projected estimates of the developmentally disabled population in Michigan for a three year period. The estimated number in 1974 is 276,0[illegible] individuals of all ages, using a 3% estimated incidence.

About 22% of the estimated number were identified in this Project as receiving some type of service.

Numbers Identified for Services

The numbers currently served include about 78,334 in daily programming as follows:

	Teachers	Students
A. Special Education Classes (1972-73)	3,101	36,813
This includes:		
Educable (Types A and C classes)	2,329	28,689
Trainable classes	522	6,624
44 Day Training Centers	250	1,500
B. Fifty Adult Activity Centers		1,307
C. 72 Sheltered Workshops		3,300 (apx)
D. NARC On-Job-Training Project		101

In addition to those identified in daily programs, there are 13,257 in some type of residential placement outside of the family home, as follows:

Type of Facility	Number Facilities	Number Served
State MR Institutions	11	8,529
MR Approved Nursing Homes	6	473
Social Services Special Homes-MR Disturbed	2	25
Pvt. Boarding Schools for MR	3	158
Wayne Center-Nursing Home Clients	53	435
Hoover Nursing Home	1	140
Mental Health Group Homes	63	1,192
Social Services-Family Care Homes	(apx)250	500
Mental Health-Foster Family Care		700
Social Services-Adult Foster Care		1,105
Total		13,257

TABLE 1

CURRENT AND PROJECTED ESTIMATES OF THE DEVELOPMENTALLY DISABLED POPULATION IN MICHIGAN FOR 1974, 1975, 1976[a,b,c]

	1974	1975	1976
Region I	10,729	10,578	10,611
Region II	9,651	9,751	9,835
Bay	5,982	6,033	6,090
Berrien-Cass	6,424	6,474	6,536
Branch-Calhoun	4,361	4,412	4,416
Central Michigan	3,667	4,733	4,794
Flint	17,736	18,010	18,267
Grand Rapids	15,393	15,422	15,656
Huron-Tuscola	2,497	2,521	2,529
Jackson-Hillsdale	5,532	5,564	5,596
Kalamazoo	11,918	13,106	13,275
Lansing	11,038	12,212	12,384
Macomb	21,119	21,716	22,321
Muskegon	11,084	11,264	11,363
Oakland	29,538	30,119	30,706
Port Huron	4,758	4,825	4,859
Saginaw	6,806	6,949	7,024
Southeastern	15,552	15,760	16,068
Wayne	79,688	79,455	79,356
TOTALS	276,013	278,474	280,995

[a]Estimates based on 3% of the general population based on the Population Projections of the counties in Michigan, Research Division, Bureau of Programs and Budget, Executive Office, State of Michigan, December, 1972. (The 3% estimate was derived as a best estimate of the total developmentally disabled population in collaboration with Mr. Paul Tobey, Cadre Coordinator, Mr. Robert Mayberry, United Cerebral Palsy, and Dr. Phillip Rennick, Epilepsy Center of Michigan.)

[b]Robert Mayberry of the United Cerebral Palsy Association estimates that there are approximately 20,000 Cerebral Palsy individuals in Michigan. In a number of instances there will be overlap with mental retardation.

[c]Dr. Phillip Rennick, Director of Psychosocial Research, Epilepsy Center of Michigan, estimates that approximately 10% of the developmentally disabled population would have accompanying seizure disorders. This compares with an estimate of 1% of the general population of Michigan.

There were 52 on the Michigan Department of Mental Health waiting list for placement in state institutions for the mentally retarded as of 12/31/73.

Still another category exists of non-daily services for the retarded which includes a total of 7,486

Vocational Rehabilitation	apx. 2,666
Social Services	2,382
Community Mental Health	2,434
Child Guidance Clinics	4

The Michigan Association for Retarded Children and Adults Social Services Committee surveyed local associations for the retarded to determine the numbers of retarded individuals waiting for services. They reported the following results from incomplete returns:

Community Service	Number Waiting
Day Training Classes	65
Adult Activity Centers	518
Work Activity Centers	273
Sheltered Workshops	219
Leisure Skills	408
Total Waiting	1,483

Large numbers of residents have been moved from institutions to the community during the past few years. For example, in 1969 there were over 12,000 residents of state institutions for the retarded. There are currently less than 8,000 residents, or an average decrease per year of about 1,000 residents.

Included next is information regarding State Homes and Training Schools, followed by a report of the community findings.

A. STATE HOME AND TRAINING SCHOOLS

The Institutional Population and Programs

In December, 1973 developmentally disabled persons residing in 11 State institutions in Michigan numbered 7,920.[1] Of this total 7,559 persons were statistically accounted for in programmatic data supplied by the Michigan Department of Mental Health.[2] (See page 25 for program definitions.) Adult residents constitute a large portion of those persons residing in the state facilities. This is exemplified by the fact that 5,458 persons out of the 7,559 total or 72.2% of the residents are 18 years of age or older. This characteristic held true upon examining the statistical information for each institution.[3] Only three (3) facilities had populations of less than 69% adults. Of the three (3) facilities one was specifically oriented to servicing mostly teenagers, and is currently being phased out. The other two facilities (Muskegon and Plymouth) each have approximately 50% adults, despite the fact that one provides specialized evaluation and treatment program/services for the blind and deaf-blind retarded.

Adults

Examination of institution program alternatives for adult residents indicates:[4]

1) Adults (18 or over) constitute characteristically high numbers (consistent with the overall distribution percentages indicated in Table 1) of those serviced within the program categories. Only .3% of those served in "Adult Activities" are under age 18, since this program is by definition for adults. Programs such as Habilitation, Nursery-Toddler, Pre-school and the three educational programs (Trainable/Educable, Trainable, and Educable) were specifically designed for the needs of a younger population and as would be expected have a larger population of children.

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[1] Macomb-Oakland Center with a population of 409 was visited during the project year. Statistical data regarding those serviced by the facility, however, is excluded from the tabulations because all persons served reside in community residential facilities. (See Table A, Appendix C.)

[2] All percentages are calculated with the statistically accounted for program totals as devisors where possible. (220 males and 141 females had invalid or unknown program codes. (See Tables B and C, Appendix C.)

[3] See Table 2, p. 26.

[4] See Table 3, p. 27.

PROGRAM DEFINITIONS

Trainable/Educable

Trainable

- 7 to 21 years
- I.Q. 30-50

Educable

Ages - 7 to 21 years
- I.Q. 50-70

Physically Handicapped

- 7 years and older
- I.Q. less than or equal to 70
- Physical defects which require special care and training

Growth and Development/Adult Activity

Growth and Development

- 7 to 21 years
- I.Q. less than or equal to 30

Adult Activity

- 21 years and older
- I.Q. less than or equal to 30

Vocational Training

- 18 to 45 years
- I.Q. 30-70
- Pre-vocational experience and exploration

Nursery Pre-School

- under 7 years
- I.Q. less than or equal to 70

Behavior Treatment

- Ambulatory residents with behavior problems of such severity that they are unable to remain in their regular programs

Visually Handicapped

- No definition available

Infirmary

- Birth and up
- I.Q. less than or equal to 70
- Emphasis on medical and skilled or basic nursing services

Source: Program definitions supplied by Lansing Regional Inter-Agency Coordinating Committee, as prepared at the Coldwater State Home and Training School.

TABLE 2

ADULTS (AGE 18 OR OVER) AND CHILDREN (AGE 0-18) RESIDING IN STATE HOME AND TRAINING SCHOOLS[a]

12/31/73

INSTITUTION	POPULATION TOTAL	NUMBER OF PERSONS 18+	PERCENT OF 18+	NUMBER OF CHILDREN	PERCENT OF CHILDREN
Alpine	138	106	76.8	38	23.2
Caro	988	758	76.7	229	23.3
Center for Human Development	1,026	711	69.3	315	30.7
Coldwater	1,530	1,074	70.2	456	29.8
Hillcrest	320	228	71.3	92	28.7
Muskegon	261	135	51.7	126	48.3
Northville	170	123	72.4	47	27.6
Newberry	362	269	74.3	99	25.7
Oakdale	1,903	1,528	80.3	375	19.7
Plymouth	1,053	518	49.2	535	50.8
Wayne Co.	169	10	5.9	161	94.1
Totals	7,559	5,458	72.2	2,473	32.7

[a]See Tables A, B and C, Appendix C. Totals by institution include 220 males and 141 females that have invalid or unknown program codes, while number of persons by age do not include these persons. Consequently the total of adults and children may not equal the sum of the individual population totals specified. Institution percentages calculated for children are derived as the difference between the adult percentage and 100%, while the overall percentage is calculated from the total number divided by the statistically accounted for total. The sum of the percentages for adults and children, therefore, do not equal 100%.

TABLE 3

PROGRAM PARTICIPATION OF ADULTS (AGE 18+) AND CHILDREN (AGE 0-18) RESIDING IN STATE HOME AND TRAINING SCHOOLS

12/31/73

	ADULTS		CHILDREN							
			0 - 5		6 - 12		13 - 17		TOTAL	
PROGRAM CATEGORIES	TOTAL #	% OF ADULTS	#	% OF TOTAL IN AGE GROUP	#	% OF TOTAL IN AGE GROUP	#	% OF TOTAL IN AGE GROUP	#	% OF ALL CHILDREN
Physcially Handicapped and Infirm	1164	21.3	68	60.7	314	39.7	454	28.9	836	33.8
Growth & Development and Habilitation	719	13.2	15	13.4	286	36.1	601	38.3	902	36.5
Adult Activities	2421	44.4	1	.9	1	.1	6	.4	8	.3
Vocational Training and Education	803	14.7	--	--	76	9.6	283	18.0	359	14.5
Behavior Treatment	153	2.8	3	2.7	6	.8	28	1.8	37	1.5
Other*	198	3.6	25	22.3	109	13.8	197	12.6	331	13.4
Totals	5458	100.0	112	100.0	792	100.1	1569	100.0	2473	100.0

*Other includes those with invalid or unknown program codes as well as 133 persons in such program categories as Blind, Deaf, Nursery-Toddler.

SOURCE: Date derived from Michigan Department of Mental Health supplied reports as summarized in Tables A, B, and C, Appendix C.

2) Of the 5,458 adults 1,164, or roughly 1/5, would appear to be formally identified as being infirm or physically handicapped. Approximately 15% of the adults are currently involved in vocational training and/or educational programs. Whether or not the bulk of these approximately 800 persons are in the 18-25 age range is not indicated in the data supplied. It is clear, however, that 44% of the adults are involved in the program category of Adult Activities. Within Adult Activities, programming may or may not be developmentally geared, whereas, for at least 13.2% of the adults there is still placement in Habilitation or Growth and Development programs. Within these two programs there is almost invariably, at least official recognition of developmental needs for those participating.

   Adults with behavior problems severe enough to warrant segregated programming constitute only 2.8% of the total number of resident adults, however, 79.3% of those served in such programs were adults. Possible related gaps in community programming will be discussed in this regard in a later section.

3) The overall institutional population is weighted in terms of male residents. (See Table B, Appendix C.) Identified adult female residents (2,338) constituted approximately 30% of the population while adult males numbered 3,120 or roughly 39% of the total (7,920) residents. Within the adult population of 5,458 , females constitute 42.9% and the males 57.1%. Adult females participating in infirmary programs numbered 392 or 53.9% of the adults served in the program which is higher than the overall percentage of females in the adult population. Interestingly, adult participation in vocational training programs is slightly over 71% male. This percentage is higher (71% vs 57%) than the overall percentage of males in the adult institutional population.

4) The statistic of 155 residents 65 years of age or older, points to a briefly addressed at-risk group in terms of prospects for community placement. (See Tables A and B, Appendix C.) Of these aged residents 101 are in Adult Activity programs with little access to community offered senior citizen activities. An additional 105 persons are being serviced by the institution while on convalescent status and/or residing in other facilities.[5] Most significant is the fact that there are 948 persons of ages 51-64 on the Book Census. This would certainly appear to be a group of persons in perpetual risk of institutionalization if returned to communities without appropriately developed supportive services

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[5]Michigan Department of Mental Health, Report #49027-1 dated 12/31/73.

Children

Children (2,473 between the ages of 0 to 18) constituted 31.2% of the total institutional residents (7,920) in Michigan as of December 31, 1973. (Of the statistically accounted for by program codes, children made up 32.7% of the 7,559 total.)[6] Approximately 1,000 additional children are included in the Book Census of the institutions, as being served while on convalescent status and/or residing in non-institution facilities. Percentages of children are consistent by institution, with only three exceptions which are noted in the discussion on the adult population.

The institution population of children may usefully be examined by programmatic participation and age.[7]

1. Adolescents (in the age range 13 through 17) numbered 1,569 and equalled 63.5% of the institutionalized children. Those programmatically identified as physically handicapped and infirm (454) made up 28.9% of the adolescent population. This figure compares with 314 or 39.7% of those aged 6-12 being so classified. A review of the 0-5 age range indicates 60.7% of that age group or 68 persons are physically handicapped or infirm. Since only 33.8% of the total population of children is programmatically so classified the increasingly greater percentages of the younger children being admitted to institutions with such handicaps is note worthy. This significant fact could be easily overlooked by simply regarding the 33.8% figure which is an accurate reflection of the total population of children. It could also be easily overlooked since the total institution population consists of only 112 persons (4.5% of the population) in the age range 0-5. A major program implication from these figures is that the institution service system is addressing a need which is conversely a gap in community programming.
2. Large numbers of children in the age range 6-12 (902 or 36.5%) are in Growth and Development and Habilitation programs which the Department of Mental Health Staff has compared to the Day Care training level resident served by the State Department of Education.[8] Corresponding to the large percentages of 0-5 age residents with physical handicaps there is a drop in the Growth and Development Habilitation participation in this age range.

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[6]See Table 2, p. 26.

[7]See Table 3, p. 27.

[8]Interdepartmental Task Force on Education in State Institutions; Survey of Residents, 1/17/74.

3. Children participating in education and training programs comprise another 14.5% of the population, leaving a final 13.4% scattered throughout the four remaining program categories of Blind, Deaf, Nursery Toddler, and Pre-school. In addition, 198 children have unknown or invalid program codes. Of particular significance is the low number of children participating in educational programs of equal quality (as specified under P.A. 198) to children residing in their own or other community homes. Statewide six out of seven age eligible residents (0-25) are not receiving such programs.[9] This significant service gap is addressed on page 63 of this document.

Specific areas of program delivery not reflected in the above noted population data, and identified service gaps drawn from the previous data evaluation will now be addressed.

Secondary Handicaps: Adults and Children

Hearing and Speech/Language Impairments

As of December 31, 1973, 3,348 secondary handicaps have been identified for residents of State Home and Training Schools.[10] This figure does not represent a percentage of the institutional population, however, since any resident can be counted in multiple categories. The pervasiveness and the multiplicity of secondarily handicapping conditions in the state institutions must be approached by analysis of data from a variety of sources.

The Michigan Department of Public Health Plan for 1972-73 indicates an estimated incidence of hearing handicaps in all Michigan children at about 3-5% of the child population. Disorders of speech and language retardation are estimated at 7-10% of the general population of Michigan children.[11] However, Mr. David Katt, a Speech and Audiological Consultant

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[9] Interdepartmental Task Force on Education in State Institutions, Summary of Minutes 4/18/74, p. 1.

[10] Michigan Department of Mental Health, Report #41037-1, "Number of Patients with Handicaps by Institution," as of 12/31/73. (See Table D, Appendix C.)

[11] Michigan Department of Public Health, 1973 Maternal and Child Health Program Plan, p. 46.

within the Department of Public Health indicates that, based on accumulated data in Michigan, the incidence rate for the entire mentally retarded population is about 12%.[12] He notes, however, that with the moderate to profoundly retarded residing in State facilities (based on accumulated data between 1968 and 1971) the expected rate is about one out of three.[13] Since one would expect the state institutions to be serving this moderate to profoundly retarded population it is significant to observe that there are only 435 identified hearing losses in the State facilities.[14] This represents only 5.5% of the population; however, utilizing the one out of three figure one would expect 2,640 identified hearing handicaps. It would appear unlikely that between the data collections of 1968-1971 and the current date, incidence rates could have dropped so dramatically, particularly since current institution admissions are typically more multiply handicapped.

Currently screening for hearing impairments in consultation with the Department of Public Health is only completed in four of the 11 State institutions. The other institutions primarily use their own staff, independent consultants, or consultants from other institutions. According to the latest data supplied by the Department of Mental Health[15] there were 13 speech therapists and audiologists on staffs at institutions statewide. Even given identification overlap between the 435 hearing handicaps and 430 speech and language handicaps it is doubtful that the speech therapists would be spending all of their time with hearing impaired persons and/or in fact doing only hearing screening. Audiology

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[12]David Katt, Focus on Mental Retardation: Specifically Ear Health, March, 1972, p. 1.

[13]Ibid., p. 2.

[14]Michigan Department of Mental Health, Report #41037-1, op. cit.

[15]Michigan Department of Mental Health, Report #13547-5, "Personnel-State Hospitals and Institutions," Pay Period ending 6/30/73. (More recent data was unavailable as of 5/23/74.) (See Table E, Appendix C.)

technicians are being used to assist in screening, however, the number utilized statewide can not be identified out of the 30 noted technicians and specialists plus assistants (in all areas).[16] If the figure of 17 staff persons for 11 institutions is utilized (even given the problems noted) the ratio of such staff to residents for hearing screening purposes is 1:466. Utilizing the 1964 AAMD standards specifying a recommended ratio of 1:400,[17] staffing is not adequate and would indicate an immediate need for a minimum of three more staff persons. This staff need does not take into account the unidentified needs for the services of qualified otologists both in screening and follow-up care. Approximately 65% of the hearing losses in moderate to profoundly retarded children can be expected to be conductive losses which require otological examination and usually aggressive medical treatment and monitoring."[18]

During the institutional surveys a count was not made of numbers of amplification devices, however, very few such devices were observed. Staff responses to questions about hearing impairments and need for amplification devices included (paraphrased):

1) They were not practical since other children would pull them off and break them.
2) Aids would not be tolerated by the retarded person.
3) Amplification devices would not help enough to be worth the trouble.
4) They (the residents) break them (aids) so often that Crippled Children's won't pay for them any more. Now we wait until just before a resident is 21 and buy one through Crippled Children's.

In comparing responses on the confidential Attendent Survey and the Program Director/Supervisor Staff Survey related to multiple handicaps an interesting

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[16] Ibid.

[17] These ratios were established at a time when institutional populations consisted of larger numbers of mildly retarded persons. These persons would have lower incidences of hearing impairments and would not reflect current population characteristics as related to difficulties of testing.

[18] Katt, op. cit., p. 7.

factor emerges. Nine out of 14 sampled attendants have received instruction on how to use and adjust adaptive aids, and 12 out of the 14 feel confident in assisting residents with these aids. However, only one out of six asked indicated they have been trained in behavior shaping techniques sufficiently to train a resident to accept an adaptive aid. It may be that the confidence expressed relates to use and adjustment of equipment. The frustration, however, may relate to relatively minimal training in behavior management for which the resident inadvertently pays the price, i.e., problems are used as rationale for not supplying equipment.

Additional survey observations by project staff included:

1) At one institution, with 69 identified hearing impairments, there were minimal individualized recommendations for auditory stimulation and communication training.
2) At least half of the institutions, as represented by their staffs, indicated they did not use individualized manual or oral communication methods as part of developmental programming.
3) In only one of the institutions surveyed were non-verbal residents taught signing.
4) The Michigan School for the Deaf was not utilized for programming consultation by any institution.

Visual Impairment

The incidence of visual impairment among the mentally retarded is estimated as being 2-4 times higher than the rate in the general population.[19] In a mass program of vision screening with 6,158 mentally retarded children[20] it was found that 21% (1,313 persons) failed initial screening. Subsequent medical follow-up indicated 90% of this number (1,182) were found to have significant uncorrected defects. The screening in Detroit, Michigan was conducted with a largely educable mentally retarded population which might lead us to predict that incidence rates among the more severely retarded would be at least that high. Mr. Radke, a State Public Health

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[19] Michigan Department of Public Health, op. cit., p. 51.

[20] Robert Blackhurst, M.D., and Edmund Radke, "Testing Retarded Children for Defects in Vision," Reprint of article in Children, Volume 13, 3, May-June, 1966, pp. 109-12.

Consultant indicates that testing procedures can be modified to the ability level of children more severely involved than the mildly retarded.[21] He further stresses the importance of such screening.[22]

Vision screening, as indicated in the Project Survey, is currently carried out in State Home and Training Schools with great variability. Consultation from the State Public Health Department is completely voluntary although training of technicians is a service offered by that Department. There is no routine Public Health Vision screening in any of the 10 residential institutions visited. Despite the variability of this service the Department of Mental Health has identified 857 cases of visual impairments.[23] This figure represents 10.8% of the total institutional population of 7,920, and falls far short of the numbers which could likely be so identified. The Department of Mental Health personnel report[24] does not specify numbers of staff in this area. However, a summary of services offered as indicated by the Project Survey indicates:

Vision Service Offered	Number of Institutions
Preliminary Screening Only	1
Admission and Annual	2
Hospital Clinic on Grounds	5
Purchased Service Nearby	1
Utilized another State Institution	3
Obtain independent consultation from another institution, Public Health, ISMRRD. etc.	2

Program staff attitudes as expressed to Project Staff were very similar to that expressed regarding auditory service needs, i.e., the older residents "had reached their potential," glasses might be destroyed by other residents, etc. Frustrations expressed by attendant staff once again related to a lack of techniques to train the residents to keep glasses on. Additional observations were:

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[21] Ibid., p. 110, and Personal Interview, October, 1973.

[22] Ibid.

[23] Department of Mental Health, Report #41037-1, op. cit.

[24] Department of Mental Health, Report #13547-5, op. cit.

1) Very few glasses were seen in any of the 10 institutional residences visited.

2) In one institution 10 "blind" residents in Adult Activities had no specialized program offered to them which included training techniques suitable for this impairment.

3) Sighted residents and visually impaired residents were mixed in seven out of 10 institutions, however, at only three institutions was it specified that living units were arranged to enhance mobility and self-care functions.

4) Efforts were made at six out of 10 institutions to provide sensory training and mobility programs. Independent travel in and out of the institution was not actively pursued.

5) Consultative Services from the Michigan School for the Blind were not utilized.

Convulsive Disorders

The expected incidence of seizure patterns with mental retardation overlay has been estimated to be about 10% (or 30,000 persons) of the developmentally disabled population in Michigan.[25] In what manner this expected percentage would vary with the moderate to profoundly retarded was not noted. The Michigan Department of Mental Health has identified 1,488 convulsive disorder handicaps[26] among its residents in state institutions for the mentally retarded. This figure would represent about 18.7% of the total population of the State Home and Training Schools. Whether or not this higher percentage reflects a higher incidence among the more involved retarded which is a characteristic of the current institution population is a matter of speculation. Screening for convulsive disorders is done by 39 medical doctors at a ratio of 1:187.[27] During the Project Survey admission screening and annual physicals were designated as the times that screening was offered at all institutions. Records were available to indicate regular medication review--

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[25]Phillip Rennick, Ph.d., Director of Psychosocial Research, Epilepsy Center of Michigan, May, 1974.

[26]Michigan Department of Mental Health, Report #41037-1, op. cit.

[27]Michigan Department of Mental Health, Report #13547-5, op. cit.

some at 60 and some at 90 days. The comprehensiveness of these reviews was not evaluated in the Project Survey. It is interesting, however, to reflect upon the fact that estimates of percentages of individual institution residents receiving anti-convulsant and/or tranquilizing drugs by institution staff varied all the way from 33 to 75% (with more estimates clustering near 75%).

Personnel overall expressed confidence in knowing procedures to follow in the event of seizures. Seizures per se were not expressed as a factor in determining participation in recreational or training activities.

Motor or Neuro-Musculo-Skeletal Impairments

In a study completed for the purpose of characterizing an institution's child population, secondary handicaps, care needs for these and implications of the data for planning and organizing other programs were investigated. It was found that neurological conditions and their musculo-skeletal complications accounted for the greatest frequency of secondary handicaps.[28] Hydrocephalus, contractures and scoliosis were described as being in large part subject to secondary prevention. In current institutional data only 138 identified cases of motor impairment are indicated statewide. Although this small number may in part be due to definitional problems (i.e., when is a motor impairment identifiable as a separate handicap over and above severe neurological and other involvements) a figure of only 1.7% of the population does seem to be very low. This seems particularly true since the number of persons programmatically accounted for as being physically handicapped is 632 and those in the Infirmary program statewide number 1,362. (See Tables A, B, and C, Appendix C.)

Formalized screening for motor impairments occurs at the time of admission and during annual physicals. As noted previously, there is a staff of 39 medical doctors to direct screening and provide direction for follow-up services provided by professional occupational (10) and

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[28] Donald C. Smith, M.D., et. al., "Health Care for Institutionalized Retarded Children," Reprint from American Journal of Mental Deficiency, September, 1968, Vol. 73, pp. 283-293.

physical therapists (6) statewide.[29] Adequate on-going prescriptive evaluation and programming would appear to be an almost physical impossibility given current professional staffing. Using the total of 1,860 motor and sensory impaired children (ages 0-25)[30] the figure of 16 occupational and physical therapists provides a ratio of 1:116 (not counting the needs of the adult population.) 1964 AAMD Standards suggest a ratio of 1:16. Even given superior in-service training with attendant staff for implementation of habilitative programs this staffing would appear to fall far short of that necessary for screening and active developmental training in these handicap areas. The Project Survey indicated:

1) Efforts to improve or maintain physical functioning through body positioning and/or assistive or adaptive devices vary.
   a) In seven institutions staff indicated use of such devices. (Very few were observed)
   b) A limited number of leg braces were observed.
   c) Efforts to develop head control and sitting balance by ordering head supports on wheel chairs, and asking residents to lift their head while speaking were observed at five institutions.
2) Equipment for floor mat activities to encourage balance and gross motor coordination was stated to be available at five facilities. At one such facility, however, discussions with the attendant staff person indicated the mats had not been used for a month.
3) A need for more wheel chairs was expressed at all institutions by both program supervisory staff and attendant staff. Individually prescribed wheel chairs were recognized as a program need at two facilities.
4) One institution had a very large and well equipped physical therapy room which was not utilized during the day of the Project Survey. Other facilities had less space and equipment. There was very obvious evidence, however, that several creative program supervisors were finding ways to gradually acquire such space and equipment, and were finding means of building in approximating activities when there was increased staff available.

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[29] Michigan Department of Mental Health, Report #13547-5, op. cit.

[30] Data submitted for Educational program planning at the Interdepartmental Task Force on Education in State Institutions, January 17, 1974.

5) Specific, individualized program goals (to improve physical functioning by increasing muscle strength and gross motor coordination to prevent contractures) were usually not available on the wards for utilization by attendant staff. Such goals were more apparent in Medicaid approved units, and may have been in supportive service professional files, but were not readily available for incorporating into the daily routine.

6) Adaptation of the physical environment to promote ambulation, use of wheel chair and walkers also varied in each facility.

   a) Five facilities gave direct evidence of efforts in this regard.
   b) Three of the five had some wall rails and bars for pulling erect. These arrangements were more apparent in buildings where redesigning had occurred to meet Medicaid standards.

7) Walkers were observed as being minimally available.

8) Wheel chair use was often restricted to halls and/or day room areas (the Survey was conducted over the Fall and Winter). Frequently so many residents were in the area that little mobility was possible and crawling and creeping opportunities limited.

Behavior Disorders

In a "Survey of Residents" conducted by the Department of Mental Health[31] 413 children (0-25) were identified as having behavior disorders which were identifiable as handicaps overlapping with mental retardation. An estimate of the adult population can be made by utilizing the Behavior Treatment program data (122 adults 21 years or older).[32] This figure does include a four year age overlap, however, since four facilities do not indicate persons in Behavior Treatment programs it is doubtful that use of this figure would inflate the estimate. This is particularly true

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[31] Ibid.

[32] See Table 5, Appendix C. Data by age categories beginning or ending at age 26 was not available from the Department of Mental Health.

since one of those facilities has recently opened a unit specializing in services to 40 such persons. The initial population for this unit will be drawn from the Wayne County facility currently being phased out (which is one of those indicating no persons in a Behavior Treatment program). In addition, a number of residents were observed (during the Project Survey) in Adult Activities and Infirmary units with self abusive behaviors so severe that hand binding and restriction of movement was necessitated. Given these considerations even a rough estimate of 550 persons would appear to be an under estimate rather than an over estimate of the institutional population with behavior disorders. Skilled professional staff trained to provide therapy and/or training direction included one psychiatrist and 23 pschologists statewide.[33] Some educators, social workers and occupational therapists could possibly be included in the staff tabulation, but this number cannot be tabulated from the data available. At first glance this staffing ratio (approximately 1:23) appears fairly adequate. However, with overlapping job responsibilities for the general population of the institutions, (i.e., intelligence testing, consultation for developmental programming, therapy, etc.) it is clear that a major portion of many of these persons' time is not, and indeed cannot be, spent with those residents with behavior disorders. This means that much of the follow-up responsibility falls upon attendant care staff who are already frequently either untrained for this responsibility and/or feel they cannot implement programs given their other responsibilities. Given 1974-75 budget recommendations (with corresponding staff cuts)[34] it would seem unlikely that services provided could greatly improve
orders characterized by aggressive acting-out behaviors. These behaviors, because of their obvious visibility, probably do not get missed in the daily observational "screening" of attendant staff. Many mentally retarded persons in institutional settings, however, develop self-stimulatory

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[33]Department of Mental Health, Report #13547-5, op. cit.

[34]As discussed at the Superintendent's Meeting, 2/7/74.

behavior mannerisms which go unaddressed because they do not interfere with daily custodial routines, and/or they are discounted as behaviors characteristic of the retarded. Appropriate staffing both in quality and quantity for on-going screening of these problems is certainly not addressed by the current staff ratios.

Diagnosis and Individual Program Evaluation

Among the 11 institutions surveyed there was rather substantial variability in regard to the perceived role of the institution related to individualized diagnosis and program evaluation.[35] Out of 14 total responses five institution administrative representatives indicated that the institution should be the primary evaluation and diagnostic center for the mentally retarded. Within their framework, Act 54 resources and the Title VI resources of the Department of Education were viewed as supportive to the institution. Three other responses, however, indicated that Act 54 Boards should support this function and other local resources should be utilized prior to drawing upon the back-up resources of the institution. Two responses were that intake takes place in doctors' offices and hospitals, and subsequent diagnosis and evaluation takes place and should remain controlled from that central point.

There were two responses emphasizing the importance of prevention both for mental retardation and institutionalization, and one indicating institutions should not be viewed as doing whatever anyone else can't do.

The variability of responses regarding where professional responsibility for assessment, at the point of entry into the service delivery system, ought to occur typifies the lack of consensus regarding roles throughout the delivery system. Philosophically most persons agreed that the institution should be but one alternative (usually a back-up resource) within the service delivery system. In practice, however, the role of the institution varies by the geographical area and its related economics as well as by how well developed community programs

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[35] See Project Survey, Administrative Interview Guide, and Program Director/Supervisor, Interview Guide, Appendix A. (Multiple responses are possible.)

and services are, and by other factors. The manner in which community alternatives affect institutional roles was exemplified in the area of screening for secondary handicaps, i.e., it would appear that once a developmentally disabled person becomes a resident of an institution he becomes dependent upon that facility to provide almost all of the services that "normal" persons outside the institution find available through generic agencies. Health Screening Services, offered through County Health Departments and community hospital and school clinics, are but minimally available to institution residents. The Department of Mental Health must provide facilities and medical and supportive staff on site, rather than providing consulting specialists to facilities and services already available in the community.

This particular type of service and consequent staffing demand (which was obvious in the discussion of understaffing for health screening purposes) is particularly acute when released residents cannot be serviced in communities. Many of the institutions provide opportunities for annual physicals and dental services to mentally retarded persons living in community facilities when appropriate services cannot be obtained in the community. Annual physicals for residents are usually scheduled around the time of their birthday, although medication is reviewed on a 60-90 day schedule. Dental screening which also usually occurs annually may or may not be timed to coincide with the physical. There are 11 Dentists and eight dental aides employed by the Department of Mental Health for State Home and Training Schools.[36] (Some of these employees may be only part-time contractual employees.) The ratio of dentists to institutional residents is about 1:720 which is slightly above the upper limit of the 1:500 to 1:700 range recommended for the developmentally disabled. However, in addition to serving the institution residents, these dentals frequently provide services to residents of community group homes. (See the Project position paper regarding dental services on pages 82 to 85 of this document.) Despite the fact that at least two institutions utilize dental students for screening and

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[36]Department of Mental Health, Report #13547-6, op. cit.

routine dental care and another utilizes a dental hygienist, staff resources are certainly not adequate to meet the need. Indeed, it is questionable whether a single department could realistically expect to be funded to meet the many health care service gaps noted. Project recommendations were designed to bring multi-agency resources to bear upon these noted service gaps. (See page 130.)

The annual review mechanism is also the formal vehicle for needs assessment and individual habilitative program review which will now be addressed.

Habilitative Programming Within The State Homes and Training Schools

Individualized habilitative program plans with specific training and/or treatment objectives for all residents were not evident from case records or discussions with staff during the Project Survey. There was, however, visible evidence of exemplary programming in selected units within institutions, or in one developmental area for a number of units, at almost every institution visited. Examples of exemplary programs or creative programming innovations of particular note during the Project Survey were:

Alpine Center:	Creative utilization of the physical therapist, and subsequent provision of individualized adaptive equipment.
Caro Retardation Center:	CASH program illustrating exemplary inter-agency cooperation. Training program for 140 Growth and Development children, innovative environmental adaptations.
Center for Human Development:	Community Readiness Program.
Coldwater State Home and Training School:	Projects 32 and 16, which are personalized programs preliminary to release to the community.
Hillcrest:	Sensory awareness emphasis and obstacle course in Growth and Development unit.
Muskegon:	Language stimulation program, active foster grandparent utilization, active efforts to utilize accreditation standards.

Northville:	Newly started unit for mentally retarded persons with overlapping behavioral problems, highly praised was the Superintendent's active relationship with the parent organization.
Oakdale:	A new well equipped active infirmary unit.
Newberry:	A greatly improved "school" program providing much stimulation for those who can participate.
Plymouth:	Title I classroom in Growth and Development unit.

Two additional innovations with broader system implications than a single institution were noted:

1. The development of a standardized system for resident performance ratings (Michigan DMH/MR-Functional Behavior Profile)[37] currently being pre-tested for six months to one year at six institutions including Caro, Coldwater, Lapeer, Mt. Pleasant, Muskegon, and Northville-MR. This is a basic diagnostic, program planning and evaluation tool covering critical areas of behavioral functioning--particularly with the more profoundly retarded population.

   If further development and implementation of the DMH/MR Functional Behavior Profile occurred it would also provide an instrument for evaluation of service delivery to individuals. It could additionally provide direction for overall program evaluation and change. Currently data feedback to institutions from the central office is not programmatic in nature. It is more useful for budgetary considerations than for directly evaluating program content and effectiveness.

2. Movement toward a decentralized "unit management" system within the institutions. At the present time seven institutions have, in at least skeletal fashion, implemented the unit system of management. Within this system, units of the resident population (usually approximately 100 persons) are serviced by a staff team. The staff team consists of the direct care staff assigned to the unit of population, representatives of pertinent professionals and a program supervisor/director who bears direct line responsibility for the functioning of the team in relation to individual and overall program goals.

Team structure varies with the needs of the population, but basically includes the program supervisor, psychologist, social worker, nurse, and adjunctive therapies as well as special education teachers assigned where

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[37] Further information regarding this Profile may be obtained by contacting the Michigan Department of Mental Health.

needed. The physician is either assigned on a definite schedule and/or available as needed. The skeletal implementation at present means that a number of units only have the part-time participation of a number of professionals (many have on-going responsibility for services to several units). This type of participation limits professional contribution to developmental programming which the system was designed to facilitate. Within a complete unit system, professional department heads no longer exist with line responsibility for the functioning of the similarly trained professional. They do function to provide professional quality control by defining high standards of individual disciplinary functioning and evaluation of same.

Theoretically unit management firmly places accountability for individualized habilitative plans with the unit supervisor/director. In reality, however, functioning varies greatly depending upon number and quality of staff completing the team. In one situation where implementation has progressed the furthest the program supervisor/director meets regularly (three times a month) will all members of the team. At another facility the professionals are accountable to the program supervisor/director at the initial evaluation and annual review only. Where the unit concept is not in existence except as a basic nurse-attendant team, the daily responsibility for on-going assessment of individual needs lies with the charge nurse. The quality of programming depends to a large extent upon that person's initiative and knowledge to request appropriate supportive professional programming consultation. During the Project Survey there were repeated examples noted of competent and energetic nursing personnel failing to bring in programmatic expertise of other disciplines. This failure arose simply because they were not trained to assess needs from the perspective of the supportive discipline and were at times operating on the basis of out-dated professional stereotypes.

A major need identified directly from observations of unit management lies in the area of in-service training needs. A unit management system, particularly, points out the need for providing program supervisors/directors with additional supervision and staff management skills. Departmental systems, on the other hand, point more directly to in-service needs in the area of interdisciplinary information seeking. Additional in-service needs as itemized at two institutions for the Project are presented in a subsequent section of this document.

Despite some rather clear-cut advancements in policies for programming, and toward emphasis on daily developmental training in the State Homes and Training schools, there are also many areas where improvement needs to occur. Some problem areas are:

1. A developmental emphasis with specific objectives and on-going evaluation and change is occurring, but not throughout all programs or in all developmental areas. (One facility most nearly approximates this.)
2. The unit system overall is operating skeletally.
3. Team members in only two institutions spend their day in the units. One other institution has plans for moving professionals to the units. For a variety of reasons the other institutions have most of their professional programming in offices away from the units where they are not in easy access to direct care staff and residents. In one facility residents are removed from the unit for treatment.
4. Training trips out of the institution and to the surrounding communities occurs for only selected numbers of residents.
5. Staff (usually social work staff) which is most directly involved with community placement is very limitedly involved in habilitative training prior to resident release. One result is inappropriate matching of pre-release training to skills required for participation in the community living facility. Parents, particularly, are frequently uninvolved in institution pre-release training which would improve their skills. (One community-based program attempting to bridge this gap is that at Alpine Center.)
6. Adult Activity Programs do not differ programmatically for 21 year olds and 50 year olds in at least six of the institutions. Where it does differ it is based on amount of physical activity (less for 50 year olds) rather than kinds of activities offered.
7. Out-dated physical plants have been in many selected instances creatively redecorated and altered to make a more normal living environment. Funds for this purpose, however, have been primarily limited to renovations necessary to meet Medicaid standards--some of which may or may not be pertinent to the normalization and training needs of residents who are not medically ill. In addition to more funds, fire and safety regulations necessary for large institution settings are making small home-like adaptations very expensive and thus less possible.
8. The confidential Attendant Survey indicated that the philosophical convictions and leadership efforts of administrative and professional staff were not necessarily congruent with attendant perceptions. Of 14 attendants sampled, all but one indicated optimism about resident potential to do better. Of the residents they served, seven attendants (out of 13) even indicated that better than half the residents could improve. However, only one

saw their activities being directly connected with moving the resident out of the institution. Activities of daily living were designated as the most important things they did by eight of twelve respondents. What they did could definitely affect resident progress in these activities, but this movement was primarily to make a resident better care for himself within the institution--it was not to achieve the resident's potential and/or to increase movement out of the facility.[38] It is also questionable whether the recognized need for more staff and/or more one-to-one training is related to resident needs or direct care needs.[39] However, it is important to recognize that any improvement in staff ratios-while meeting direct care relief needs would also meet resident training needs.

9. The relatively limited number of professional programming staff directly involved on the wards is reflected in the Survey. Of 15 responses, nine indicated a greater respect for on-the-unit supervisors and the nurse than for any of the other professional staff such as doctors, psychologists, teachers, social workers, etc.[40]

   The anecdotal comments indicated direct attendant concern with visible, demonstrated knowledge of care for and programming with residents. Those professionals seen only sporadically would have less opportunity to demonstrate such competence.

10. Nearly all administrative staff questioned indicated a variety of difficulties with the State Civil Service System. Difficulties varied but included long delays in getting registers, inability to get registers for skill areas rather than by type of degree, lack of flexibility for true implementation of a "career ladder" concept, etc.

11. Volunteers and other resources such as Foster Grandparents are generally perceived as valuable programming assets by supervisory and administrative staff. In five facilities, community relations staff orient and coordinate such programs. In four other facilities there are volunteer coordinators. Task assignments are generally made by the program directors and/or ward supervisors. Some problems, however, had been experienced with regular attendance of community volunteer groups, other than students who are held responsible for attendance in their classes. Interestingly, a number of supervisors perceived attendant staff as feeling volunteers and Foster Grandparents contributions did not equal the bother of training them. In the Attendant Survey, however, most attendants indicated a

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[38] See Attendant Survey, Appendix A, p. 133.

[39] Ibid., p. 133, question 3.

[40] Ibid., p. 133, question 1.

positive feeling toward volunteers who assisted them in their job responsibilities.[41] An in-service training effort might be directed toward addressing the apparent incongruity between supervisory perceptions of attendants and the way they in fact feel.

12. Most administrators felt parents should visit whenever they wished. Within two institutions there were even report card-like vehicles for communicating with parents about their child's programming. Overall, however, parent participation in setting habilitative goals is not encouraged by any automatic administrative procedure designed to achieve that end. The attendants surveyed generally preferred no help from parents, help only in off-ward activities, or selective involvement on the wards such as on birthdays, picnics, etc.

    Outreach is made to parents more often at the time of the annual conference where release is liable to be a very real question. In four of the 11 facilities surveyed parents are definitely not involved as programming partners. They are notified of the conference and deliberately involved if it is felt by staff that it is appropriate.

    There are formal parent advisory boards and active parent associations which stress involvement beyond programming for individual residents. This input into policy development is more dependent upon aggressive parent outreach than it is upon a formal institutional policy and procedure to involve them. Several institution Superintendents were highly praised for their efforts in this area by the MARCA parents contacted as part of the Institution Survey procedure.

13. As previously indicated (see pp. 24 through 28) appropriate programmatic activity is grossly inadequate in amount and kind for 72.2% of the institutional residents who are 18 years of age or older. All areas of staffing deficits and gaps in individualized programming noted in the previous narrative would affect this major portion of the total population. In a community survey conducted by the Project there was a defined unmet need for 3,588 adult activity and sheltered workshop slots just for those already in communities. (See page 10.) This need does not include facility costs to house these programs.

14. Guidelines for community placement are not available for standardized staff utilization at each State Home and Training School. A good general model for such a set of guidelines is Denniston's Rule 234. (See Item F, Appendix C, p. 155)

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[41] Ibid., p. 134, Question 3.

15. Finally, a major service gap is that in delivery of educational programs to the six out of seven children (approximately 3400) who are currently not receiving such service. (See project position paper addressing this major need on pages 63 to 71 of this document.)

ADDITIONAL PROGRAM CONSIDERATIONS

Universities

Out of ten institution administrators asked, during the Project Survey, one-half felt the major role of the universities in serving the mentally retarded was in doing research to develop new technologies of direct intervention. (See Administrative Interview Guide, Appendix A, p. 128) Doing research to develop new technologies of service management and delivery as well as making curriculum changes for training new entrants into the professions were regarded as major roles by four of the ten administrators. Only three administrators saw the university role as one of providing extra staff, evaluative feedback, clinical support services or engaging in prevention research. Two problems noted related to utilization of the university as a resource were:

1. The need to be formally affiliated with a university in order to get useful input.
2. The need to be geographically in close proximity to enable frequent interchange through student placements, faculty involvement, etc. No administrators indicated universities, or other community agencies for that matter, as sources of change for the institution. Basically change was perceived as originating from institutional staff-initiating with administrators most frequently and proceeding downward through the bureaucratic structure. Relatives and their families and/or parent associations were noted least often as change agents within the institution (twice out of 13 designations). (See Administrative Interview Guide, Appendix A, p. 129).

Guardianship and Advocacy

Clarification of statutes and policies related to guardianship were noted by six administrators as areas of great need. These administrators were looking toward the about to be proposed Mental Health Code

for clarification in this regard.[42] The type of guardianship perceived of as important by administrators broadened that role beyond financial supervision into the area of assuming responsibility for assisting with life and health decisions and preventing of exploitation. This type of extension of guardianship really leads into the area of consumer organized client advocacy. In all probability, however, most responding administrators were not carrying the concept as far as that of a facilitator for delivery of services. One administrator in particular saw "advocacy" as what professional service providers ought to be doing.

In-Service Training Needs

In-service training needs within the institution have been directly and/or indirectly referred to throughout the report on Project Findings. As a major supplement to these designated areas of needs the Oakdale Center Training Committee met with Program Directors to identify needed curriculum content for attendant in-service training.[43] Primary suggestions were:

"1. Child growth and development (early childhood education normal and deviations from).
2. Learning theories.
3. Motor development and training (movement education).
4. Nature of retardation (to include sections on the psychological and emotional feeling and reactions upon parents, siblings and the community at large, of a parent with a handicapped family member).
5. Survey of handicapping conditions.
6. Feeding, toileting and dressing instructions or techniques.
7. How to lift, transfer skills, i.e., physically handicapped (technique of handling non-ambulatory child).

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[42]As of the current date the Proposed "Mental Health Code" has been presented to the 1974 Michigan Legislature by the Legislative Council of the Mental Health Statutes Study Sub-Committee.

[43]Letter dated 1/16/74 received from Helen B. Linehan, R.N., Chairperson, Training Committee, Oakdale Center.

8. Motivating techniques.
9. Behavior management, appropriate contingencies - relationship between a given behavior and its consequence.
10. Language or communication development.
11. Therapeutic recreation (for gross and fine motor development).
12. Varied activities - arts and crafts, music (how to structure these to improve physical or mental functioning).
13. Management system - goal setting and ways to accomplish same, i.e., management by objectives.
14. Human biology - practical, body systems and some practical information of what can go wrong. (Pressure sores - epileptic seizures, etc.)
15. Social system (group dynamics - peers use of group pressure, role playing for handicapped persons).
16. Observation - evaluation - problem solving focus on behavior, individual and groups.
17. Exposure to psychological testing - Adaptive Behavior Scale, Purdue, Wais, Stanford, etc.
18. First aid - emergency.
19. Alternative to institution care - availability, types of community placements, e.g., foster homes, parents and programming, Community Mental Health Services course could fall under community organization.

Suggestions for workshops included:

1. A workshop on the Adaptive Behavior Scale and its use as a programming tool.
2. A workshop on methods of developing psychomotor skills in children with multiple handicaps.
3. Management by objectives.
4. Behavior shaping.
5. Employee/employer relationships.
6. Feeding techniques for physically and profoundly retarded individuals."

Mr. David Rosen, Superintendent, Macomb-Oakland Residential Center most cooperatively participated in identifying additional in-service needs.[44]

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[44]Letter dated 2/11/74 from David Rosen, Superintendent, Macomb-Oakland Residential Center, p. 1.

The training needs identified were seen as particularly necessary for an institution serving residents of non-institution facilities. Included were:

1. "We have found that in-service training aimed at understanding the interagency relationships between Social Services, Public Health Departments, Mental Health clinics, school systems and other community-based agencies is critical to the functioning of an out-reach organization such as ours. With the welfare of an individual residing in the community resting on the ability of several responsible agencies to work together on his or her behalf, it is essential that professionals within those agencies have a complete familiarization with interagency policies and procedures. While the same kind of interdisciplinary and inter-departmental understanding is required within the institution, it takes on increased importance and complexity in the community. We have relied upon our own agency professionals to orientate new staff to the workings between agencies. We are also in the early stages of developing a more complete interagency training program with the agencies mentioned."
2. "As we have a strong consultant program with professionals representing several disciplines on the staff, we have found it helpful to present specialized in-service programs for the entire agency. For example, our occupational and speech therapists have presented a complete orientation program to the staff for the purpose of acquainting members with procedures for their differential therapy programs. The importance of having the entire service staff familiar with all programming methods utilized to maintain community placements is especially critical to an organization dedicated to deinstitutionalization."

Mr. Rosen also points out in his letter the great need for staff trained in how to maintain good public relations so as to reduce community resistance to placements.

Finally, the importance of staff trained to work with parents is implied since the success of community placement and deinstitutionalization is, in the last analysis, in their hands. Mr. Rosen states:

> "The operation of parent groups to work actively for community residential placements is also very important. Presently we are in the process of developing parent advisory boards that will have specialized interests in foster care, group homes, and nursing homes, as well as natural home placements. In this light, it is also a good idea to include parents and other advocates on admission committees and advisory boards."[45]

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[45] Ibid.

COMMUNITY PROGRAMS AND SERVICES

As noted previously, large numbers have moved from the institutions to communities in a short period of time. This puts increased demands on community services, and makes the service gaps much more evident. Community gaps in services were identified by the regional inter-agency survey, the adult activity center survey, and inter-disciplinary state conference, and consultations.

Regional Inter-Agency Survey Recommendations

Coordination and Planning

1. All institution commitments should go through a single community resource such as community mental health.
2. Institutional personnel in the area should be involved in regional interagency committees.
3. There should be a specialist in developmental disabilities in each one of the major agencies and at least one in their regional counterparts.
4. There should be a flow of communication upward and downward within agencies on a more systematic basis.
5. There should be a legislative mandate for community mental health to assume prime responsibility for those over 25 years of age.
6. There should be a single registry in each area of the developmentally disabled with accountability on the part of a single agency to assume leadership in a team effort for services.
7. There should be a revised criterion for institution admission.
8. There should be a standard form for more accurate information from the institution to the community for those released from the institution.
9. The regional zones for all of the major state departments should be coordinated including some consideration of Act 54 service areas and school district boundaries.
10. There should be a single human resource agency.
11. Agencies should be held responsible for specific results which are clearly spelled out.

12. There should be criteria developed for the utilization of generic and specialized services for the developmentally disabled at the community level.
13. There should be interagency case planning for the developmentally disabled including the involvement of the parent and client.
14. There should be a reduction of the 25% match requirement for Act 54.
15. There should be Act 54 involvement prior to admission to an institution to explore community alternatives.
16. There should be a systematic format for release planning shortly after admission to an institution with assignment of responsibilities in that regard.

Central Referral Service

1. There should be a regionally controlled central referral system with Life Consultation functions for the developmentally disabled.
2. This central referral system should include the coordination of services for those returned from institutions.
3. This central referral system should include record keeping and data collection.
4. The life consultation central referral system should be the intermediate schools for those 0-25 years of age and another agency for those over 25.

Diagnosis and Evaluation

1. There is a need for planned regular evaluation for institution returnees every six to twelve months.
2. There should be provision for early family contact and intervention with referral to appropriate services.
3. More program evaluation is needed on an on-going basis.

Home Counseling

1. There should be an agency responsible for community supportive services to sustain and train families, especially in the areas of behavioral counseling and developmental training. This might be the Community Mental Health Agency.
2. There should be special assistance for families with a) those just returned from institutions; b) with pre-kindergarten children--a system for early intervention. (This might include a system of D.D. families assisting other D.D. families.)
3. There is a need for parents and/or foster parents to allow their child to be visible to the community. Efforts should be made to encourage this.

Advocacy

1. Pilot advocacy projects should be initiated especially to assist the retarded in the use of community resources.
2. There should be a follow-up program for the retarded who are in independent living situations and who need specific and legal help.
3. There should be an annual advocate's report for each released resident.

Protective Services

1. There is a need for a specific plan for protective services and guardianship, with a spelling-out and clarification of the legal rights of the mentally retarded.

Guardianship

1. The need for legal guardianship should be clarified and roles for guardians should be established.

Institutional Release Preparation and Follow-Up

1. There should be specific information from the institution to the community and a definite planned community program for released residents.
2. There should be increased social work staff with community mental health responsibility assigned. Case load standards for supervision should be developed.
3. Pre-placement and readiness programs should be developed by the institution for residents about to be released.
4. There should be more preparation of foster care staff.
5. The local agency staff should be involved with the institution on pre-release planning.

Health Care

1. There should be yearly physical exams and evaluation of treatment programming.
2. There should be a specialized extended care facility for the 50 to 100 epileptic persons statewide in Michigan who have frequent severe epileptic attacks. The center should be multi-disciplinary and provide for incarceration for a three to six months period with the goal of prevention of further institutionalization.
3. A state department should be assigned the responsibility for epileptics.

4. There should be better pre-natal care and other preventive biological research to prevent developmental disabilities.
5. There is a need to reverse the trend of doctors who are refusing to take medicaid patients.
6. There is a need for a home care nursing care program and consultation for severely handicapped infants.

Dental Services

1. We need special dental services for the disabled.

Vision and Hearing Services

No recommendations.

Social Services

1. There should be expanded income maintenance for the disabled through SSI.
2. SSI funds for special living arrangements should be supplemented with mental health funds.

Respite Care

1. There should be respite care provisions with 30-60-90-day options for programs for more evaluation and treatment of problems.
2. Several mentioned the need for respite care and crisis intervention relief.
3. There might be special funding to group and/or foster home in the community to provide respite care.
4. There should be trained respite care workers to care for the D.D. person in his own home for a few hours or days.

Speech Therapy

No recommendations.

Other Special Services

1. There is a need for back-up community services for mentally ill retarded individuals to prevent institutionalization.
2. We need more expertise in the community in treating behavioral problems of the retarded, including crisis intervention services.
3. There is a need for more
emotional needs for those who are in institutions.
4. There should be more use of volunteers.
5. Senior retarded citizens should get the same benefits as other senior citizens.

Recreation

1. We need expansion of recreational programs for the multiply handicapped.
2. We need training of recreationalists to work with the multiply handicapped.
3. We need a better recreation system for people in independent living.

Religious Nurture

No recommendations.

Education and Training

1. We need a policy clarification: Under Public Law 198 can parents prevent their child from attending a school program.
2. We need a policy clarification: Can parents or guardians prevent an adult retarded person from attending a prescribed community program for the adult retarded.
3. We need more day care training services.
4. We need expanded pre-school programs.
5. We need more vocational education programs to cover all levels of handicapping needs.
6. We need parent training in care of the handicapped.

Sheltered Workshops and Employment Opportunities

1. We need an affirmative action program defined to include D.D. persons for purposes of developing employment opportunities.
2. We need policy clarification: Can parents or guardians prevent an adult retarded person from entering into competitive employment when deemed capable by licensed community agencies.
3. We need more sheltered workshops for retarded persons and more work activity centers.

Home Finding

1. We need more specialized social service staff to work on the special needs of clients in home finding. Staff should also become more knowledgeable of specific disabilities.

Community Residential Services

1. There should be immediate responsibility for licensing and regulations placed within a single agency.
2. There should be more developmental programming planned for adults beyond mandatory education age. Community Mental Health should be assigned primary responsibility for this as a provider or purchaser.

3. There should be better residential care standards for adults.
4. Program availability should be determined before placement.
5. There should be increased funding to community mental health programs for day programs and also for transportation.
6. There are not enough community residential alternatives available. (Recruitment and major public relations compaign through CMH and DSS should be funded appropriately for this.)
7. There should be better in-service education of home operators.
8. We need a small 25-bed skilled nursing unit with developmental emphasis.
9. There should be pilot projects demonstrating adequate methods for dealing with anti-social behaviors.
10. There should be a strong advocacy program to promote participation in mainstream of community life.
11. Homes should be provided near community services for daily programs.
12. Community residences should strive for the smallest possible unit with movement to larger or smaller on a planned basis. (Family home, foster-group home.)
13. There should be community monitoring of residential placements (Note section 22 of Act 118) - assigned to community mental health.
14. There should be foster care homes for newborns.
15. There should be model group homes for "at risk" persons.
16. There should be half-way houses.
17. There should be model group homes with a mix of disabilities, i.e., wheelchair patients with ambulatory patients, etc.
18. There should be apartment units with house parents supervising.

Home Management Assistance for the Adult D.D.

1. We need joint responsibility by DMH and DSS for home counseling.

Public Education

1. We need more PR and community education regarding the needs of the D.D.
2. There should be more public relations funding with work with zoning boards, local governments, etc.
3. There should be more prevention information.
4. There should be more emphasis on early diagnosis and treatment with public education.

In-Service Education for all Service Personnel

1. Service personnel should have a knowledge of program and service availability.
2. There should be in-service education for all personnel - perhaps operated through purchase of service grants.
3. Community residential operators need in-service education and developmental training information.
4. There should be more education of medical doctors about retardation. (Perhaps advocacy groups can influence the medical training relationship to retardation.)
5. There should be training in mental retardation for workers in generic as well as specialized community services. (MR specialists should be employed in generic agencies.)
6. Professionals and para-professionals should have continuous systematic education.
7. There should be a workshop for staff-parent-client on the psychosexual needs of the handicapped.
8. A resource list of available community services in addition to institutional services should be distributed to physicians.

Transportation

1. There should be paid transportation - not volunteer programs - for adult programs.
2. There should be transportation for after school leisure hours programs and to community programs.
3. We need more transportation to work activity, sheltered workshops, day care and other community programs.

Other

1. Zoning laws need to be changed through legislative action to allow for group homes.
2. State fire marshal requirements should be revised.
3. Community mental health boards should be allowed to own real estate.
4. Home operators should be given the same fringe benefits (unemployment compensation, social security, etc.) available to other workers.

Adult Activity Center Survey

Thirty-seven of the surveys mailed to the fifty Adult Activity centers were returned, with this information:

Number of spaces	2202
Number of clients	1908
Number waiting	1533

State Conference Recommendations

Additional recommendations were provided by the inter-disciplinary participants in the twenty sessions of a state workshop conference. Following are the workshop session recommendations from the Third Conference on Placement and Programming for the Mentally Retarded in Michigan, held March 11, 1974 at the Lansing Civic Center.

Institution Programs

1. Uniform procedures should be developed which preclude the release of individuals from the institutions until these conditions are met:
   a. Suitable home placement (biological, foster or group homes)
   b. Appropriate program
      Adult-work setting
      Under 25 years, school program with special services
   c. Follow-up evaluation plan with monitoring agency.
2. There is a need for a clear policy of placement planning with coordinated responsibility and follow-up services. (Need more coordination between the institution and community.)
3. The release program should not result in reduction of institution staff since accreditation staffing standards have not been met.
4. There is a need for a 50 bed residential facility for special services to those with severe epilepsy problems.

Administration and Coordination of Services

1. The regional inter-agency committee should be strengthened:
   a. Perhaps D.D. funds could be used for administrative staff to do needs assessment program planning and coordination, etc.
   b. More persons with decision-making authority should be on RICC's.
   c. Specific regional goals should be developed.
2. A state agency should assume responsibility for services to epileptics.
3. Regarding the super-agency concept, there were both positive and negative reactions with recommendations that a) the alternatives be spelled out; b) that a pilot proto-type be done at a county level; and c) who would control the purse strings?
4. There is a need for advocacy offices for life planning for the retarded.
5. The various agency regions are in conflict and should be coordinated.

6. An agency should assume primary responsibility for services for the retarded.
7. Mental health funding should follow the child to the community.
8. A resource listing of community services is needed for families who keep their handicapped child at home.
9. There should be a grandfather clause or ease-in clause for change-over from DMH to DSS licensed homes.
10. There should be more supervision of group homes.
11. Are we using manpower to the greatest advantage? For instance, we should reassess the certification process and address those needs. Professionals from institutions need to be assessed in terms of what services they can provide in the community.
12. Regional inter-agency organizations with common boundaries and paid staff should be considered as alternatives to the super-agency or in conjunction with the super-agency.
13. Placement responsibility and accountability for D.D. should be separate from the mentally ill at the state level.
14. The Regional Inter-Agency Committees should produce or promote more public information on the retarded and the epileptic.
15. Zoning currently being considered should be supported. There is a lack of zoning information at the local level. The current proposal may be to restrictive with six nonrelated residents and perhaps it should be for 10 or 12. There should be a state ruling that local communities cannot establish zoning regulations which discriminate against the retarded.
16. There should be additional state funds to support special education and Act 54 services, and also "start-up" costs for programs.
17. We need better transportation provisions.
18. The fire marshal standards for group homes should be reviewed.
19. Workmen's compensation laws should be reviewed for better provisions for the retarded and epileptic.
20. The present foster homes and group homes should be evaluated.
21. Medicaid provisions should be fully utilized with solutions made to situations where doctors refuse medicaid patients.
22. There should be a trust fund program for financial security for the retarded.

Community Services

1. There should be provisions for:
   a. Crisis intervention
   b. Respite care
   c. Home-operator training (also for problems of epilepsy)

2. More information about the patients should be given to group home operators.
3. There should be a plan for additional services for clients who live in their parents' home.
4. There should be a plan for a better educational program for those with epilepsy.
5. There should be follow-up evaluation procedures especially during the first year of placement.
6. There should be special living arrangements for those with emotional problems and in need of respite care.
7. There should be better sex education programs for the adult retarded.

C. SUMMARY OF FINDINGS

Many interesting activities are taking place in the state. For instance:

The Department of Education is establishing diagnostic centers through Title Six funds to serve the severely multiply-handicapped.

The Michigan Department of Mental Health and the Michigan Department of Education are cooperatively planning for educational programs in state institutions.

Universities are becoming more involved with practical research efforts and in-service education programs. Michigan State University recently received Federal approval to establish a world-wide network of special education services to share research findings, provide in-service education programs, and conduct research.

Private agencies are expanding their activities. For instance, the Epilepsy Center of Michigan was just awarded a grant to provide a feasibility study for a comprehensive epilepsy program in Wayne County. The Michigan Association for Retarded Children and Adults, in cooperation with the United Cerebral Palsy Association of Michigan, has been awarded a grant to develop a statewide advocacy program.

A few life consultation centers are being developed, providing a fixed point of referral and information center in the areas they serve.

The Michigan Department of Social Services has been given responsibility to be the single licensing agency for residential facilities for the retarded.

A state training program for group home operators is in the planning stages.

There is still much to do. Major issues include:

The need for better planning and coordination of services at all levels.

The need for mandated accountability for services for those over 25 years of age.

The need for life consultation centers to be developed throughout the state.

The need for improved programming and better staffing ratios within state institutions for the retarded.

The need for better pre-release programs for institution residents.

The need for improved health care services for the developmentally disabled.

The need for expanded programs (adult activity centers and sheltered workshops) for adult developmentally disabled individuals.

The need to clearly delineate the various fundings for non-family residential placements and suggest funding revisions.

POSITION PAPERS

Several issues in providing quality services to the developmentally disabled required expanded statements of positions in addition to the basic recommendations in this document.

These issues included:

- Community Placement
- Educational Programs for Residential Placements
- Nursing Homes
- Prevention
- Nutrition
- Dental Services

The Community Placement Program is examined in a separate study report from the Office of Health and Medical Affairs in Michigan. The recommendations in that study are supported in this plan.

The additional position statements follow. Each has been carefully reviewed by concerned individuals and agencies.

A. INSTITUTION-EDUCATION

Position paper on educational programs for persons up to 25 years of age residing in State Institutions or Nursing Homes for the mentally retarded.

The Position

Since the Michigan Department of Education is mandated to provide appropriate educational programs for all handicapped individuals up to the age of 25 years, this includes those residing in state institutions for the retarded and nursing homes.

Most institution residents could be served in the local community special education classes. When it is not possible to transport the residents to community special education programs, (due to the resident's physical condition) the intermediate school district is responsible for providing an on-site special education program.

In addition to employing on-site teaching personnel when needed, the intermediate school district has the same responsibility for provision of diagnostic and supportive personnel as it does for other residents in the geographical area. Title VI regional diagnostic centers should be maximally utilized in services to individuals in residential placements.

It would seem feasible that some satellite diagnostic staff, employed either by the intermediate school district or the institution might be housed at each institution. A written program plan, and all other required features of the mandatory special education act, should be available to all those working with the resident, plus the resident's parents or guardian.

Older residents may be served in community work activity centers or sheltered workshops, with school personnel involved, but administered by another agency.

The legislature should provide additional funding to those intermediate school districts whose areas include state institutions for the retarded for the purposes indicated in this statement.

The Current Situation

Educational programs, if provided, are within the institution setting, and administered by the Michigan Department of Mental Health. The teachers, who are under Civil Service, must meet the same approval standards as those in public school special education programs. Currently, there are approximately 4000 in-house residents of state institutions who are under 25 years of age. There are 41 teachers employed in the institutions, or a ratio of about one teacher per 100 students. Of the 41 teachers, twenty-two are employed with Title I federal funds as noted in Table 4 on page 65. This ratio means that there are many school-aged residents of state institutions who are not served at all by approved special education teachers or supportive staff.

In addition, the institution educational program is currently usually provided on the wards, so that the residents do not go to another facility on the institution grounds.

A small number (approximately 85) of institution residents are presently sent out to attend daily special education classes in the local school system. In addition, 143 residents of Oakdale Center in Lapeer attend the

TABLE 4

TITLE I STAFF AND SALARIES

	TEACHER	TEACHER AIDES	OTHER PROF.	TOTAL
Caro				
*Instruction $37,071	3	5	9	17
Newberry				
Instruction $83,000	1	3	2	6
	(Students Assist on Weekends)		4	4
Mt. Pleasant				
Instruction $128,000	4	2	4	10
Plymouth				
Instruction $121,054	3	0	12	15
Lapeer				
Instruction $171,618	0	13	1	14
(Other Health)		7		7
Muskegon				
Instruction-Salary $42,177	5			5
Northville				
Instruction-Salary $39,000	3			3
(With emotionally disturbed)				
Coldwater $311,400	3	11	11	25
Macomb Oakland				
TOTAL	22	41	43	136

*Instruction includes one or more of salaries for instruction, in-service education, textbooks, supplementary materials, books, supplies.

Woodside School on the institution grounds, which is administered by Lapeer Public Schools.

Diagnosis and educational planning are important components of educational programs. Currently, there are 23 psychologists at state institutions for the retarded, probably serving the total in-house population of approximately 8500 residents of all ages, yielding a ratio of one psychologist for each 371 residents.

The American Association of Mental Deficiency in its document: "Standards for State Residential Institutions for the Mentally Retarded" states:

> The number of staff psychologists required will depend upon the use of the discipline, the size and nature of the resident population and the average number of annual admissions.
>
> The following separate services are indicated with recommended numbers of psychologists based upon the volume of services rendered or the number of residents served in the different levels of retardation.
>
> a. Pre-Admission Service
> One psychologist for each 200 annual pre-admission referrals studied.
>
> b. Admission Service
> One psychologist for each 200 annual admissions.
>
> c. Special Treatment Service including Psychotherapy
> One psychologist for each caseload of 25 residents.
>
> d. Continued Care Units

Profound	Severe	Moderate	Mild and Borderline
1:400	1:300	1:200	1:100

> e. After Care
> One psychologist for each 200 complete evaluations required or 1 psychologist for each 30 intensive therapy cases served.
>
> f. Research
> Number determined by the number of hours of psychological service in research which the institution establishes as its policy based upon a 40-hour week.
>
> g. Training of Personnel
> Number determined by the actual hours of teaching and preparation expected from the psychologist in the training program for personnel.

Background Information on Written Comments and Positions

Several key documents clearly set the stage in philosophical support of the position in this paper:

National Action to Combat Mental Retardation - (page 103): "Specialized educational services must be extended and improved to provide appropriate educational opportunities for all retarded children."

(Page 137): "Every such institution including those that care for the seriously retarded,should be basically therapeutic in character and emphasis, and closely linked to appropriate medical, educational, and welfare programs in the community."

Progress Report - A Plan to Combat Mental Retardation in Michigan - (page 73): "Responsibility for the Education of Mentally Handicapped Persons Residing in State Institutions must be clarified.

. . . A high priority should be given to additional staff for educational programs at State institutions for the mentally handicapped . . . The responsibility for educational programs in State institutions is clearly stated in the Constitution."

Michigan Constitution - Article VIII - Section 3 - Leadership and general supervision over all public education, including adult education and instructional programs in state institutions, except as to institutions of higher education granting Baccalaureate degrees, is vested in a state board of education. It shall serve as the general planning and coordinating body for all public education, including higher education, and shall advise the legislature as to the financial requirements in connection therewith.

State Plan for the Delivery of Special Education Programs and Services for 1973-1974 - "Goal I: To provide every handicapped child in Michigan with comprehensive educational programs and services appropriate to his needs."

NARC Position - "Policy Statement on the Education of Mentally Retarded Children" - (page 4) - "The public educational agency charged with overseeing community education programs should have the responsibility for the education of mentally retarded persons who are in residential care settings. Teachers within these facilities should be certified in their field of competency

according to the same criteria employed in public schools. Serious consideration should be given to providing their education within community-based school facilities."

and NARC's "Action Guidelines - Evaluating and Monitoring Education Services for Mentally Retarded Persons" - (page 11) - "Such placement (in community programs) is essential in order to integrate the retarded student in the mainstream of public school education, thereby facilitating later adjustments to life in the community."

Joint Commission: Standards for Residential Facilities for the Mentally Retarded - (page 41) - "In accordance with the normalization principle, all professional services to the retarded should be rendered in the community, whenever possible, rather than in a residential facility, and where rendered in a residential facility, such services must be at least comparable to those provided the non-retarded in the community."

AAMD - Residential Standards - The AAMD standards call for a teacher-pupil ratio of no greater than 15 pupils assigned to one teacher.

(Page 34) - "Institutional programs should be planned to articulate with community programs wherever possible. With 96 percent of the mentally retarded living in communities, with the rapid expansion of community services for the retarded and with the changing concepts of institutional-community inter-dependence, it is imperative that institutional programs be articulated with community programs."

How the Proposed Educational Programs and Services Would Work

COMPONENT	ADMINISTERING AGENCY	PERSONNEL INVOLVED	FUNDING
Leadership	Intermediate School District (ISD)	Director of Special Education and Supervisors	Additional Legislative Appropriation
Diagnosis	ISD	Inter-disciplinary Team from Generic Services, Schools and Institution	Typical Sources plus Additional Appropriation
Educational Planning and Evaluation	ISD	Supervisor, ISD and Institution Inter-disciplinary Team and Parents	ISD Sources

COMPONENT	ADMINISTERING AGENCY	PERSONNEL INVOLVED	FUNDING
Teacher and Other Professional Support Personnel	ISD	Approved Sp. Ed. Personnel	ISD Sources with additional appropriation
Instructional Program	ISD	ISD Staff and Institution Staff (24-Hour Programming)	Typical Sources
Facility	ISD or Institution	N/A	Usual ISD or Institution Sources
Transportation	ISD or Institution	Drivers and Aides	ISD and Institutions

Roles and Responsibilities of Involved Agencies

State Department of Education

Leadership in the development of educational programs for developmentally disabled individuals who are in residential placements. This will require at least one additional consultant. It is recommended that the inter-departmental institution - education committee be continued.

Intensive in-service education programs to help develop a quality system of education for institution residents should be provided.

Appropriate budget requests to support the education needs of institution residents should be developed.

State Department of Mental Health

Supportive leadership in the development of educational programs for mentally retarded individuals in residential placements.

Institution or Other Residential Facility

Cooperation with the educational system which is administering the program for institution residents.

Staff time arrangements for involvement in the development of 24-hour programming, prescriptive program plans, as might be required to accomplish the education and development goals for a given resident or group of residents.

Regular, systematic communication with the educational administrators.

Involvement of the superintendent of the institution or the institution director of programs in an advisory committee.

Active involvement in the evaluation of education programs.

Intermediate School District in which the Institution is Located

The intermediate school district superintendent as delegated to the director of special education or other surrogate would be responsible for the provision of the educational program for institution residents. The program would be preferably in the local community - outside of the institution grounds in order to enhance the normalization process.

The superintendent and the director of special education are responsible for arranging for the same quality of educational provisions for institution residents as required for those coming from family homes.

In addition, the director of special education would be responsible for:

Billing the local school district in which the parents reside for educational costs for those residents whose home community is elsewhere. (Note Education Rule 32.)

Working cooperatively with institution personnel in arranging for transportation, in-service education programs, the development of an advisory committee and all other phases of program planning and evaluation.

Arranging for regular communication with the parents of the individuals served in cooperation with the institution.

The Local School District in which the Resident's Parents Reside

Assumes cost responsibility for its residents who are placed in a residential facility within another intermediate school district.

The Local School District

Includes the institution residents in special education classes based upon the plan with the intermediate school district, and is involved with all phases of planning for the quality development of programs.

Places the institution residents with other students from the community schools program in the special education classes.

Legislature

Supports via adequate appropriations for the special needs in developing quality programs to serve this group of citizens.

Parents

Responsibility for involvement in planning, evaluating, etc., and being closely tied in with the educational program.

Summary of Position

In summary, we are submitting the position that we must implement the already existing provisions in this state, and provide as normal as possible an education program for residents of institutions and nursing homes for the mentally retarded.

We are taking the position that the Michigan Department of Education is responsible for providing education to all handicapped individuals up to 25 years of age. Furthermore, such educational programs, wherever possible, should be provided in local community special education classes, outside of the institution grounds. Those few individuals of school age who could not be transported to local special education programs would have a special education program provided by the local or intermediate school district at the institution.

Such a provision calls for maximal levels of cooperation and teamwork on the part of all agencies and individuals concerned.

B. NURSING HOMES

There are two types of nursing homes in Michigan in which the developmentally disabled individual may be placed. They are:

1. A regular nursing home with other patients from the general population, or
2. An approved mental retardation nursing home.

The standards for the certification of mental retardation nursing homes were approved on April 2, 1973. Thus, this type of nursing home is a developing program with some specific quality controls, including rules and regulations which define the expectations of the state for such programs. In addition to the establishment of such programs, the Department of Mental

Health has a policy[1] defining its position regarding non-compliance with the approved mental retardation nursing home regulation.

> "It is the Department's position that an Agreement will be cancelled with any nursing home who fails to meet rules, regulations, standards, provide required level of skilled care and demonstrates lack of compliance with the spirit and intent of the Mental Retardation Skilled Nursing Home Program at any phase of implementation of the Agreement."

As of March 5, 1974, the following six approved mental retardation nursing homes have been developed:

Nursing Home	Number of Residents
Ogemaw Valley (Rose City)	100
Monroe Care Center	103
Michigan Skilled Care (Oshtemo)	101
Town and Country (Midland)	28
Genesee Skilled Care (Flint)	101
Detroit	40
Total	473

Approved mental retardation nursing homes must have a minimum capacity of 25 and a maximum capacity of 150. Attached is the Michigan Department of Mental Health criteria for the selection of residents. An interesting arrangement with state institutions for the retarded has been developed as part of the licensing process. The State institution is responsible for supplying one full-time employee for each 25 mental retardation beds or major fraction thereof in each mental retardation nursing home. They also are responsible for supplying one full time supervisor for each five full time state employees assigned to mental retardation nursing home programs.

The one state employee for twenty-five patients is responsbile for coordinating and assisting in specialized developmental and habilitative training programs for the mentally retarded residents. The institution also

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[1] Letter dated 9/13/73 from Miss Evelyn Provitt of Mental Health to Mr. Harvey Zuckerberg, of the Michigan Association for Retarded Children and Adults.

provides consultative service in nursing care, education, developmental and habilitative program and whatever other problems arise. They have provided in-service education programs for the total nursing home personnel.

Major Strengths of Mental Retardation Nursing Homes

1. They are closer to the community than the institution, and provide a better opportunity of individual return to community functioning than the institution because of this closeness.
2. Nursing homes are new and modern with semi-private rooms with baths, and other special structural accomadations to meet medicaid standards.
3. The staff provided by the state institutions for the retarded is a distinct program asset, with special background preparation patterns, such as Occupational Therapy.
4. The residents have a less highly structured routine at the nursing home than they did at the institution.
5. Devices such as wheelchairs are brought with the patients from the institutions to the approved nursing homes.
6. There is a written individual evaluation form for each resident.

Major Weaknesses of Mental Retardation Approved Nursing Homes

1. Individualized programming is still in a state of development and not as comprehensive as it should be.
2. There is a question about the appropriateness of placement of some of the patients inasmuch as they may not all be in need of 24-hour nursing care.
3. The nursing homes lack program equipment.
4. There is little systematic tie-in with community resources, such as schools, community mental health service boards, county health departments, etc.
5. There is limited physical therapy (staff or equipment) available in the nursing homes.
6. There is sometimes high staff turnover caused in part by the disparity between the low nursing home wages in contrast to the higher wages paid to staff supplied by the institutions.
7. The total 24-hour program coordination between the various supervisors in each nursing home needs to be better defined.

Project Position

The Project has taken an affirmative position supporting the development of an appropriate number of approved mental retardation nursing homes in Michigan. It is felt this is a step nearer to more normal community living.

Currently, 60% of state institution residents are physically handicapped or infirm, and thus potential candidates for nursing homes. The following recommendations are included for improvement of the current mental retardation nursing home provisions:

1. The Michigan Department of Mental Health should employ a consultant responsible for a leadership role in the development of approved mental retardation nursing home programs.
2. Approved mental retardation nursing homes should be pre-planned with local community agencies and resources. The other agencies should have a specific liaison person assigned to the nursing home. The mental retardation nursing home program supervisor should actively assume the community liaison role from the nursing home.
3. Careful attention should be given to assuring that each approved mental retardation nursing home meets the specified regulations for state certification and has appropriate residents placed within the facility.
4. The preparation requirements of program staff (supplied by the institution) should be reviewed by a committee of program staff representatives and the consultant from the Michigan Department of Mental Health.
5. A uniform plan for the evaluation of staff and programs should be developed.
6. All appropriate community service resources should be utilized by the nursing home including:
   a) educational programs supplied by the schools within the community including access to regional diagnostic centers;
   b) adult activity centers and sheltered workshops;
   c) local health department services;
   d) community mental health boards services - including evaluation assistance and life consultation services;
   e) recreational facilities and programs from the general community which must be made accessible to the non-ambulatory;
   f) the use of volunteers from the community;
   g) churches; and
   h) the involvement of consumer organizations.
7. A community advisory committee should be established for the nursing homes in each regional area with well defined representation, including consumer membership.
8. A system of regular staff communication with the resident's family to discuss progress and to actively involve them in the development of program goals should be established.

9. There should be a written individualized program for each resident over and above the nursing care plan.

10. There should be a movement plan to other facilities when appropriate so that the nursing home is not viewed as a final placement facility.

11. There should be central coordination within the facility with authority for implementing a 24-hour complete program for the resident.

12. There should be adequate habilitation equipment (including physical therapy provisions) within the nursing home or regularly available to the residents in the community. Toilet areas with small stools should be available for habilitation training of the young residents.

13. A sub-committee, including the six current program supervisors in approved mental retardation nursing homes, should develop a well defined role description for the program supervisors.

14. The community liaison aspect of the program mental retardation nursing homes should immediately be more specifically defined. This definition development would be a part of the task assigned to a sub-committee (six current program supervisors plus one representative from DMH) which would be appointed by Mental Health to define clearly the total role of nursing home program supervisors. Consideration should be given to assigning the task of community liaison on a full time basis to a qualified professional.

15. Individual medication prescriptions should be intensely reviewed and a system for periodic review established.

16. A representative (probably the program supervisor) of the approved mental retardation nursing home shoul actively participate in the meetings of the regional interagency coordinating committee in the area.

17. Special attention should be given to assuring proper medical and health screening services for the residents, including physical therapy, vision health, hearing conservation and dental care.

18. Residents should not be withheld from community programs and/or services because of lack of transportation. These arrangements should be developed as an integral part of individualized as well as overall program planning.

Criteria For Selection of Residents for
Mental Retardation Skilled Nursing Homes
(Michigan Department of Mental Health)

1. Residents shall be mentally retarded with measured intellectual functioning of less than 50 I.Q. (Exceptions to I.Q. level may be granted by the Director of the Department of Mental Health only upon receipt of request with the rationale for exception from the Superintendent.)

2. Residents shall be medically infirmed, medically fragile and/or have incapacitating physical handicaps and disabilities which require that they receive on-going medical surveillance, medical care and services under the direction of a physician and 24-hour a day nursing care under the direction of licensed professional nursing personnel.

   a. Residents can be of any age, infant through senior citizen.
   b. Ambulatory residents must have the condition of being medically infirmed with a medical and nursing care problem to be eligible (not just physically fragile and require protective environment).
   c. Non-ambulatory residents with severe contractures, or at risk of acquiring contractures unless intensive physical therapy treatments and on-going skillful nursing care is provided (i.e., spastic cases) are elibilbe candidates.

3. Residents whose intellectual functioning is subnormal due to senility, cultural deprivation, or accidents which occurred after early childhood are to be excluded.

4. The need for a protective living environment due to physical fragility is not a criterion for nursing home placement in and of itself. (Residents who are physically fragile and require a protective, fully supportive environment may be cared for better or, as well, in a supervised sheltered living situation such as a foster/family care home.)

5. Non-ambulatory residents (a) who do not have a specific medical or nursing care problem, (b) who do not require care under the direction of licensed professional nursing personnel, (c) but, rather, require continuous basic physical care and (d) are dependent for life support services are to be excluded.

   (For example, residents with severe physical handicaps whose (a) immobility status is stable and would be essentially unchanged by professional nursing and/or intensive physical therapy treatments, (b) is mobil via wheelchair, braces, crutches, floor wheel moving carts, etc., (c) requires careful supervision, and (d) good basic physical care and life support services, rather than nursing care by licensed nursing personnel.)

6. Blindness, deafness (or other sensory impairment) is not a criterion for nursing home placement in and of itself.

7. If a resident's condition is suitable for and it is determined he or she could be placed in an appropriate family care home or group home, the resident should not be identified for nursing home placement.

C. PREVENTION

The Michigan Department of Public Health should continue to provide leadership in the area of prevention of developmental disabilities. This leadership is in partnership with other resources, such as private practitioners, universities, and other agencies.

A sub-committee of the Cadre should be appointed to concentrate on developing and monitoring state goals in the area of Prevention. The sub-committee membership should include private practitioners, university researchers and public health specialists, plus a specialist in sociology.

Attention should be given to both primary and secondary prevention of developmental disabilities. Primary prevention includes comprehensive programs of maternal and child health care in addition to a consideration of environmental factors. Secondary prevention includes a consideration of habilitative programs and services to help developmentally disabled persons achieve their maximum potential. Many of the specific recommendations in this plan refer to secondary prevention.

Efforts should be made to develop:

a) A state-wide early hearing testing program (similar to the vision testing program).
b) Perinatal intensive care centers.
c) An expanded state-wide lead poisoning detection project - similar to that currently in operation in Detroit.
d) More public information about resources, such as the Genetics Institute at the University of Michigan and the similar activities at Michigan State University.
e) An action program in infantile spasms in cooperation with appropriate resources including the Epilepsy Center of Michigan.
f) An intensive public information program (perhaps through the schools and through parent organizations) on such areas as Nutrition, etc.

This sub-committee should make specific recommendations for a plan of action to the Cadre, which would be responsible for appropriately prodding follow-up implementation efforts.

The Department of Public Health should continue to stress public information and/or action programs for:

a) PKU
b) RH factor
c) High risk mothers and infants
d) Family planning
e) Maternal and Child Care (pre and post - natal)
f) Better social conditions for the "at risk" population
g) Research

D. NEED FOR NUTRITION SERVICES FOR THE HANDICAPPED

The assistance of Marie T. Weber, Nutrition Consultant, Nutrition Section and Molly Graber, Nutrition Consultant, Maternal and Child Health, both from the Michigan Department of Public Health is greatly appreciated. They have written the information on Nutrition Services which follows.

Nutrition is a vital part of the comprehensive care and rehabilitation of handicapped children. Nutrition is an important factor in prevention at the primary and secondary level of such conditions.

Nutrition as a prevention at the primary level: There are many studies that indicate that the nutritional status of the mother is associated with the birth weight and length of a baby as well as the incidence of prematurity. Low birth weights and prematurity carry a higher incidence of infant mortality and residual morbidity--mental retardation, cerebral palsy and epilepsy. The younger the mother, the more important role nutrition holds. Work done on animals shows a correlation between maternal nutrition and the number of brain cells in a newborn. Malnutrition of the newborn may result in lessened brain cell divisions up to age one year and even into the preschool years: this will vary with the degree of deprivation. In addition to causing mental retardation is the fact that malnourished children are more likely to be listless, apathetic, limited in attention span, fatigued and restless.

Nutritional Status of Handicapped Children: There are few studies of the nutritional status of handicapped children. Summaries of various studies indicate the following: feeding problems related to physically handicapping conditions, need for special preparation of foods, obesity, disturbed interpersonal relations affecting food intake, height and weight below the normal standards, low hemoglobins, poor food habits, and delayed feeding skills.

Nutritional Needs of a Handicapped Child (Secondary Level): Good nutrition is needed for growth and development in the same manner as a normal growing child requires it. For some handicapped children proper nutrition may be one of the most important factors in survival and development into useful and productive members of society.

Self-feeding skills are an important part of daily living activities. Not only does this skill contribute to the rehabilitation process, but a child will normally eat better when he is capable of feeding himself.

The speech pathology of a handicapped child also relates to nutrition. Both the nutritionist and the speech pathologist are concerned with the structure and function of the oral mechanism. In order to achieve adequate nutrition the child must develop appropriate feeding skills which include abilities of chewing, sucking, and swallowing. The physical structures needed for eating are the same structures used for the more basic functions of breathing, sucking, mastication and deglutition.

The type of diet that a handicapped child needs may be related to the child's condition; i.e., consistency of food, biochemical composition of the foods (in metabolic disorders), therapeutic diets, and the cultural food patterns of the family.

The parent's education on sound nutritional principles is an important need for the handicapped child. Unknowing parents may contribute to the health problems by using rich snack foods as rewards for a child who appears to have few other pleasures. Parents must be taught about the child's basic condition; dietary needs; selection of suitable foods; food budgeting and purchasing; food preparation; feeding techniques; the atmosphere of mealtime within a home; and participation of the handicapped child in family activities including meals.

Prevention of obesity is important for all handicapped children, but especially in children where mobilization is a problem. It is also a well-known fact that childhood obesity may be a forerunner of adult obesity, atherosclerosis, diabetes and other degenerative diseases. Handicapped children appear to have a high incidence of obesity.

Handicapped children are prone to a high incidence of cavities because of difficulty in brushing and flossing of teeth as well as excessive intakes of concentrated sweets and carbohydrates. Education of parents and child is needed in this condition.

In Conclusion: Evidence from several studies indicates that nutrition may be one of the important factors in primary prevention (e.g., early malnutrition) of some handicapping conditions in infancy and childhood. The evidence of good nutrition in secondary prevention and rehabilitation for many handicapped children is quite evident from the studies submitted and practical experience. It is therefore our firm conviction that nutrition services delivered by a qualified nutritionist are a necessary component of good quality programming and service delivery for the handicapped.

Suggested Guidelines for Nutrition Services for Supportive Services Personnel Under Michigan Mandatory Special Education Public Act 198

I. Goal

The goal of a nutrition component in a Program for Special Education as a part of the supportive services in the public schools is to assist school personnel in helping children to meet their nutritional needs for growth and health.

II. Services of the Dietitian or Nutritionist

1. Screens all children enrolled to identify those that need an evaluation of nutritional status. Obtains a general knowledge of food intakes and physical findings of the target population.

2. Evaluates the nutritional status of those children who were identified in the screening process by the following three methods:

Dietary method:--24 hour recall technique is used to obtain information on the current eating habits: nutrition adequacy, frequency of food use, meal and snack times, etc. In addition, the following information is obtained: height and weight, difficulties in sucking, chewing or swallowing, use of special diet, feeding skills, food likes and dislikes, unusual food cravings, food allergies, vitamin supplementation or other medication, food buying habits, play activities and sleep and toilet habits. If necessary, the nutritional status of the mother during pregnancy of the client-patient and the feeding history of the client-patient himself during infancy is investigated. A three day food record may be requested if further study of dietary intake is necessary or if the reliability of the data collected by the diet history technique is questionable. Observation of a feeding session may also aid in the evaluation and planning of counseling procedures.

Clinical method--special attention will be made to such general features as pallor, apathy, and irritability. Signs of nutritional deficiencies in the hair, eyes, tongue, skin, nails and skeletal system will be noted. Consultation with the physician will be necessary when these signs are noticeable. Data on stature, weight and head circumference will be recorded.

Biochemical method--routine serum iron hemoglobin and hematocrit determinations are propsed for children below six years old. Routine Vitamin B Complex determinations for children on drug therapy because of learning problems are recommended. When dietary intake records show questionable nutrient intakes, selected blood and serum nutrient determinations will be recommended. For example, if food intake data or clinical examinations suggest the possibility of ascorbic acid or protein deficiency, high priority will be given to determination of concentrations of ascorbic acid and albumin in sera.

3. Determines the nutrient requirements for children with handicapping conditions which show increased requirements for certain nutrients. Published reports have shown that children on dilantin or phenobarbital may show higher folic acid requirements. If biochemical determinations confirm the need for more folic acid, counseling on dietary modification or nutrient supplementation will follow.
4. Prescribes and modifies diets to meet the nutrient needs of individual children. Examples of health problems requiring modified diets are: overweight, obesity, hypoglycemia and seizures.
5. Evaluates the feeding skills of the child taking into consideration the person's feeding capabilities in relation to current developmental level. Makes recommendations in consultation with occupational and physical therapy, nursing, or other disciplines as appropriate.
6. Counsels parents and school personnel regarding the diet modifications needed by individual children. Also counsels on food selection, preparation and service.
7. Participates in rehabilitation programs through assessment of individuals' abilities to perform homemaking skills, particularly in the area of food planning, purchasing, preparation and service. Develops and implements training programs in food service.
8. Makes appropriate referrals to other health and social services in the community.
9. Consults with direct providers of food service for the handicapped on:
   a. menu planning, purchasing, preparation and service.
   b. development of nutrition education programs within the total child feeding program and in-service training program with food services personnel.

10. Carries out public relations activities with community groups to interpret the role of nutrition in the prevention of handicapping conditions and the management of the handicapped.
11. Provides consultation to special educators relative to the:
    a. integration of nutrition concepts and skills in the curriculum for the educables and trainables.
    b. development of teaching materials such as pictorial recipes for cooking classes or games making use of food models.
    c. use of food as reinforcers in behavior modification programs.
12. Develops and directs a nutrition education program involving students, their parents and selected agency personnel. For example, a program for children who are underweight, overweight or obese.
13. Recommends appropriate nutrition publication or sources of printed or audio-visual materials to school personnel and parents.

E. DENTAL SERVICES FOR THE DEVELOPMENTALLY DISABLED

Appreciation is expressed to Dr. Howard Mehaffey, Chief of the Dental Division, Michigan Department of Public Health, for extensive assistance in this section.

Dental services may be provided by the private dentist through a community medical facility, or through a specialized service. It is expected that a majority of the developmentally disabled would be served through private dental offices.

Factors which may create the need for referral to dental services other than those normally used by the general population include:

a) Severe retardation which creates unresponsiveness to commands in the dental chair;
b) Severe physical problems, such as cerebral palsy, which prevent appropriate responses in the dental chair (or prevent the individual from coming to the dental chair);
c) Extensive dental needs created by years of dental neglect, compounded by disability problems, which makes generic dental service impractical;
d) Lack of generic dental services for larger residential facilities.

This would include large institutions, nursing homes and community group homes. Since massive numbers have recently been moved out of institutions and into community facilities, this creates both interim and long range problems (often in terms of sheer numbers) in providing generic dental services.

Current Dental Service Resources

Professional Preparation in Michigan

a. Two (2) Dental Schools: University of Michigan and University of Detroit
b. Nine (9) Higher Education Facilities are preparing Dental Hygienists

Services

a. Generic Services
b. Pedodontists (A current state manpower study is indicating approximately 55 in the state, primarily in metropolitan areas.)
c. Special Hospital Clinics, such as Blodget, Upjohn, Mott Clinic and Wyandotte Hospital
d. Mental Health facilities including dental units-Pontiac Medical Unit; State institutions (part-time)-Recall patients in nursing and foster homes
e. U.P. - Two (2) Dental Vans for five (5) counties
f. Dental School Clinics-(U. of M. has two mobile vans with three dental chairs in each)
g. All Health Departments must have a Dental Department director (may be part-time) and some have Dental Clinics
h. There are three (3) dentists in the Dental Division of the Michigan Department of Public Health, plus five (5) regional Title 19 dental consultants.

Recommended Level of Dental Services

The recommended ratio of dentists for the general population is one to 1500-1800 persons and not more than 1:2500. The recommended ratio for the developmentally disabled is one dentist to every 500-700 disabled individuals who are in need of specialized dental services.

Dental services should include:

I. Primary Prevention - (Pre-pathogenesis)
   a. early and periodic screening of needs
   b. utilization of fluorides
   c. plaque control program (cognitive-skill development)
      active
      passive (with assistance of another person or use of gadget)
   d. dental health education (informational, training, motivational)
      1. parent
      2. personnel (institution, nursing home)
      3. child
   e. examination
      1. digital
      2. x-ray
      3. charting
   f. treatment planning

II. Secondary Prevention - (Post-Pathogenesis)
   a. Relief of pain and infection
   b. Restoration of primary and permanent teeth
   c. Pulp therapy
   d. Treatment of oral infection
   e. Extractions

III. Tertiary Prevention - (Rehabilitation)
   a. Prosthetic Appliances
      1. fixed
      2. removeable
   b. Orthodontic care
   c. Cosmetic surgery

Plan of Action

1. Regional Inter-Agency Committees should assess available resources for dental services and make plans to utilize state-wide resources including those for in-service education of professionals. They should also make plans for home assistance in methods of providing good dental care and information about special tooth brushes and dental floss gadgets.

2. Institutions, nursing homes and group homes should make specific assignments to assure that patients are brushing their teeth daily and if possible, using dental floss. One method to cover everyone within a 24 hour period (to prevent permanent plaque build-up) would be to have 1/3 of the residents brush their teeth during each shift. A six (6) months dental check-up of residents should occur. Additional dentists should be employed to provide an adequate level of dental care to residents.

3. Residents of state institutions should be evaluated by dental consultants, and the Department of Mental Health should develop a plan of specific action to provide at least minimal preventive and restorative care for each resident.

4. Dentists should be encouraged to utilize dental hygienists, especially in the treatment of the developmentally disabled.

5. Through the leadership of the Dental Division of the Michigan Department of Public Health, the feasibility of a specialized two (2) year preparation program for Dental Hygienists to work with the developmentally disabled should be explored. Other leadership functions to be provided include:
   a. The in-service training of key area dentists to work with the developmentally disabled through the use of all possible resources, including the five (5) area Title 19 dental consultants (to be planned with regional inter-agency committees).
   b. The inter-disciplinary training involvement of the Institute for the Study of Mental Retardation and Related Disabilities (ISMR-RD) at the U. of M. (with the regional use of the two (2) vans from their school of Dentistry).

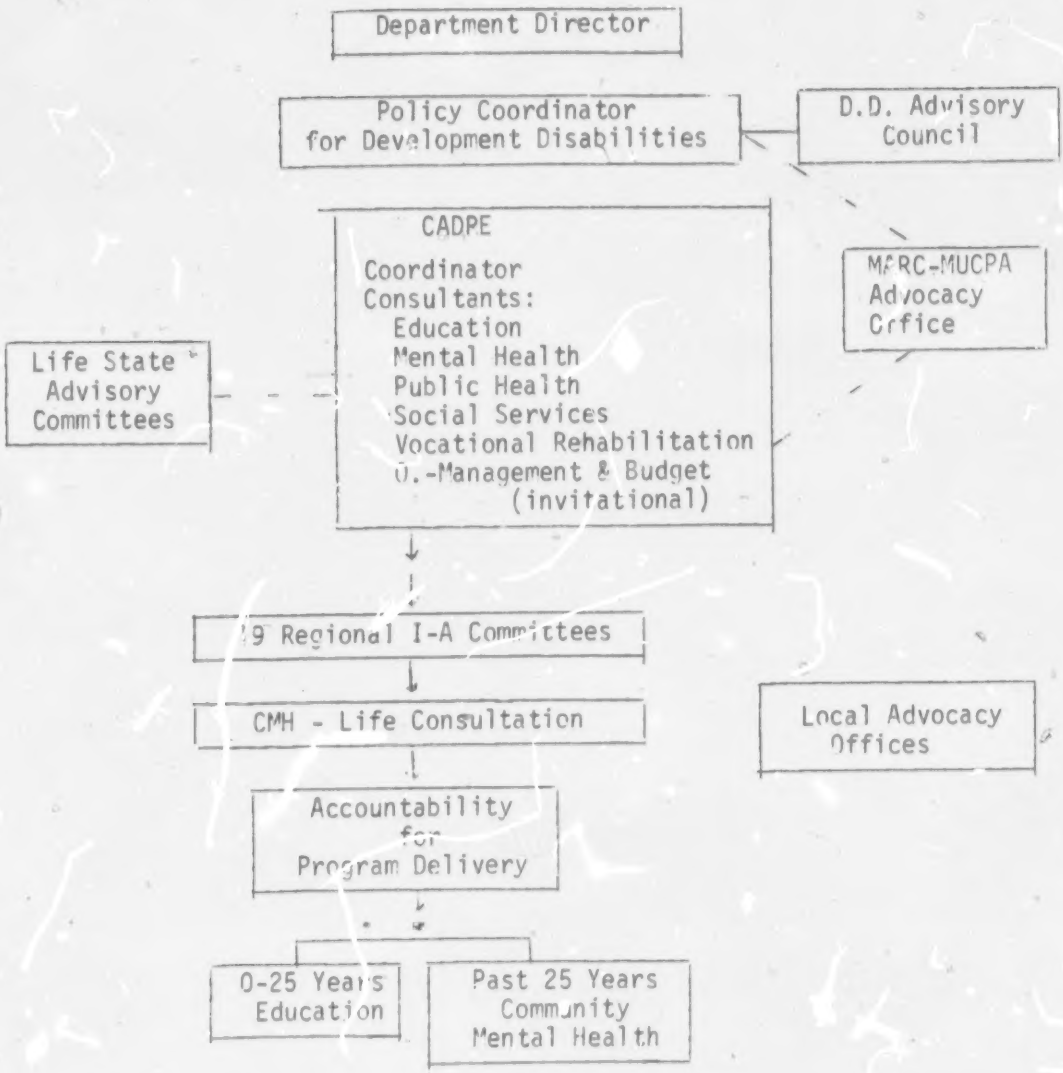
c. Involving the local health departments dental sections in assisting other community professionals in providing counseling to parents of the developmentally disabled regarding appropriate dental care.
d. Exploring possible funding sources for additional in-service education needs.
e. In cooperation with the state Cadre, a pamphlet with information about possible dental services for different types of developmentally disabled individuals should be developed and distributed to all dentists.

6. Universities should assure students of pre-service preparation contacts with the developmentally disabled. Dentists and dental hygienists should have a specific planned contact with several types of developmentally disabled patients in various types of settings, including institutions.

   In addition, in-service education regarding dental services for the developmentally disabled is urgently needed. (The U. of M. vans could be utilized regionally for this practical contact).

7. In cooperation with the state Cadre, the Dental Division of the Michigan Department of Public Health should annually review needs and progress in this area.

PROPOSED ORGANIZATIONAL CHART



STATE, REGIONAL, LOCAL INTERAGENCY PLANNING AND SERVICE DELIVERY COORDINATION

The planning and service delivery model was developed as a coordinative vehicle designed to address major areas of service gaps identified by the Institution Survey and the Regional Interagency Committee Surveys. The State and regional organization model remains basically in its current form, with major emphasis instead being placed upon refining structural compositions and definitions of duties in such a manner as to more greatly pinpoint responsibilities.

The Developmental Disabilities Council

The Council would retain its current composition, i.e., membership representing each of the principal state agencies serving the developmentally disabled. The Council function of setting goals, establishing policy and evaluating progress should be reemphasized. A greater structuring of the Cadre input to the Council could greatly facilitate these activities. It is recommended, therefore, that position papers related to the Developmentally Disabled Advisory Council goals be developed by the Cadre for regular review and action of the Council.

The Interagency Cadre

It is recommended that the State Cadre remain organizationally located within the Department of Public Health in conjunction with its responsibility as the single state agency designated to receive developmental disabilities funds. A major project recommendation, however, would be that should the State Department of Human Services become a reality, the Cadre coordinator position should be within that department, and should be functionally responsible to the Developmental Disabilities Policy Advisor. The Developmental Disabilities Policy Advisor would in turn be responsible to the Department Director.

State Agencies responsible for assigning Cadre participants should select persons whose training and departmental roles include a major emphasis on mental retardation and specifically related disabilities. A visible

indication of individual department commitment to interagency functioning would include the supportive activities of:

1. Reviewing current intradepartmental staff assignments for purposes of singling out those scattered interagency tasks which are currently being performed; and
2. Bringing together these currently uncoordinated tasks into a recognized, functional role with accompanying possibilities for commitments of time by one staff person, i.e,. the Cadre participant.

These individual departmental activities would more carefully ensure that Cadre participants, regardless of their organizational level, would be better able to enunciate and apply policies of the agencies they represent. In addition, the Cadre, as a group, would be better able to deal with its general responsibilities of planning and coordination as well as completing the specific agenda items to be noted.

The Cadre coordinator would be better able to direct the Cadre toward task completion. Several cooperative positions have been recommended as additions to current Cadre participation (by invitation). They include:

1. the Office of Services to the Aging which has a legally defined role in planning for services to the elderly under Titles III and VII of the Older Americans Act; and
2. the Office of Management and Budget which already plays a vital role in actualizing programs and services to the developmentally disabled. Selected input by this office (OMB) could provide important input to sensitizing that office to human service needs as well as providing the Cadre with information regarding interagency budgeting as it relates to feasible policy recommendations to the Council.

Recommended general Cadre responsibilities include:

1. The assignment of "primary planner" role to various departmental members. The primary planners on the Cadre would carry major responsibility for interagency planning, coordination and policy facilitation with the RICCs. Designated primary planning responsibility corresponds, in the main, to the life stage needs for which the various agencies are currently providing primary program delivery. This correspondence facilitates Cadre task activities by efficiently utilizing existing areas of expertise. All other Cadre participants would provide input to the primary planners as needed. Individual agency assignments include:

a.	Prevention	Department of Public Health
b.	Infants (0-3)	Department of Public Health and Department of Education
c.	Pre-school (3-6)	Department of Education
d.	Childhood School Years (6-12)	Department of Education
e.	Adolescent Years (13-18)	Department of Education
f.	Young Adults (19-30)	Department of Education (including the Division of Vocational Rehabilitation) and Department of Mental Health - (After age 25 or prior to age 25 if an educational program has been completed.)
g.	Adult Years (Approx. 31-64)	Department of Mental Health and Department of Social Services
h.	Elderly (65+)	Department of Social Services Office of Services to the Aging- (cooperative participation)

2. Meeting regularly and sharing concerns.
3. Reviewing all existing provisions for the Developmentally Disabled.
4. Assisting Regional Interagency Planning and Coordination offices in the development of their area service delivery plans.
5. Utilizing the regional plans for development of and review of the state plan.
6. Defining reasons for gaps in services within a particular system (such as an institution) and making feasible recommendations to assist in closing these gaps.
7. Planning needed new or revised legislation.
8. Communicating committee information to appropriate persons in their parent agencies.
9. Completing quarterly reports for Developmentally Disabilities Council review.
10. Encouraging action research. (A "grass-roots" approach to empirical and not highly structured research is urged, so that all persons working with the developmentally disabled may be stimulated to try new ideas.)
11. Responsibility for a quarterly newsletter, denoting progress toward state Developmental Disability goals and sharing information; especially with the Developmental Disabilities Advisory Council and the Regional Interagency Offices. All possible resources including universities should be utilized in this effort. Included should be:

Interagency budgeting

Planning action research

Health Services - Nutrition, Dental Care, Epilepsy, etc.

Evaluation Procedures

Interagency case services

12. Studying the unique problems involved in attempting to serve multiply handicapped children in sparsely populated areas, i.e., locations of service facilities, etc.

13. Liaison with appropriate consumer agencies and advisory committees.

The following specific agenda for immediate action on the part of the Cadre Coordinator plus the Cadre is presented as a result of interagency recommendations to the Project. These agenda items should be undertaken and progress reports with policy recommendations developed for Advisory Council action.

1. Request the Chairman of the Developmental Disabilities Advisory Council (Dr. Reizen) to appoint a sub-committee to recommend a more systematic and productive mode of operation for the Advisory Council. Suggested sub-committee membership is Dr. Thomas Kirk, Chairman; plus two members of the Advisory Council and the Cadre.

2. Specifically request a liaison person from the Office of Management and Budget (through Dr. John Dempsey) for communication at regular intervals by meeting with the Interagency Cadre.

3. Assist in the development of comprehensive programs at State institutions including the implementation of educational responsibilities for institution-education programs and other programs with emphasis on community location of programs and increased utilization of existing community resources in general.

4. Request each agency head to make a statement of reaffirmation of support of the interagency efforts of the Cadre including this specific agenda.

5. Take an active role in the appropriate total development of nursing homes, with specific actions to implement the recommendations made in a section of this document on nursing homes.

6. Review all of the existing agency regulations so that each Cadre member will become conversant especially with licensing requirements for the various programs.

7. Provide leadership in assisting the Department of Vocational Rehabilitation to provide appropriate services to the severely developmentally disabled as specified in the Project recommendations.

8. Actively participate in the evaluation of local programs.

9. Develop a recommended interdepartmental policy regarding transportation provisions to all daily programs for the developmentally disabled for submission to and action by the Council. (Recommend legislation where needed.)
10. Work with the Office of Health and Medical Affairs regarding the implementation of this State Plan.
11. Work with the legislative committee which is studying group and foster homes to revise funding provisions.
12. Develop a position paper with a suggested pattern for the institution dollar to follow the individual released to the community for his initial community program placement provision.
13. Appoint sub-committees with state and local membership composition to have an on-going study and action recommendation program in at least the following areas:
    a. In-service education plans (special emphasis should be made to initially develop the in-service education specialized state facility within the Oakland Act 54 Board Mental Retardation Services area.)
    b. Primary Prevention Efforts
    c. Public Information (efforts should be made to involve the specialists in this area from each one of the agencies.)
14. Assume the responsibility for up-dating the handbook developed this year by the MARCA Special Projects Office.
15. Review community college and university preparation and in-service education programs (with appropriate resource help) which are provided for developmental disabilities programs and services in terms of needed revisions. Special attention should be given to the preparation programs for those in medicine.
16. Assume an especially active role in developing guidelines for comprehensive services for the pre-school developmentally disabled.
17. Aggressively participate in the appropriate development of Life Consultation Center Offices through Community Mental Health Boards.
18. Work especially intensely with the development of the interdisciplinary leadership role of regional interagency coordinating committees, as specified on page 92.

Regional Planning and Coordination Offices

The 19 Regional Interagency Committees should review the appropriateness of their boundaries in consultation with the State Cadre. Consideration should be given to changing to the "State Planning and Development Regions" so that voluntary cooperation in regard to other areas of community services planning can more easily take place. Based upon substantiated need, Developmental Disabilities grants should be given to selected regions to support a full-

time professional coordinator and secretary to be housed in one of the existing regional agencies. Specific line functions between the Regional Coordinator and the State Cadre Coordinator's office would be established, but should specifically include inter-disciplinary leadership via:

1. Inter-disciplinary information dispensing through a newsletter publication.
2. Development of a regional plan with a time-line. (In cooperation with the State Cadre.) The Plan would include:
   a. Identification of service needs with input from local inter-disciplinary offices and advocacy units - to include in-service training and research and grant needs.
   b. Recommendations for improved planning and coordination of services to meet these identified needs. Input would be made to the State Cadre and Developmental Disabilities Office for guidance of state planning.
   c. Recommendations related to a time-line and methodology for evaluation of progress in regard to recommendations in the plan.
   d. Annual review and recommendations for updating the Service Delivery Model which pinpoints service delivery responsibilities of the various agencies.
3. Quarterly progress reports for submission to the State Cadre and the Developmental Disabilities Coordinator. Review and recommendations would be made at the State level with specific assistance given when problems in achieving goals are evidenced.
4. Systematic communication with Advisory Committees and Consumer Organizations - with these agencies directly involved in case appeal reviews and evaluations.

Local Service Delivery

Responsibility for delivery of services at the local level rests by statute with the various State agencies. Currently, no agency has been assigned accountability for development and monitoring of appropriate individualized service plans, however. It is recommended that the State Department of Mental Health define as a budgetary priority, the establishment of Life Consultation offices for the Developmentally Disabled by the Act 54 Boards to specifically meet this need. The Life Consultation function would include that of a fixed referral point, family counseling in regard to the service delivery network and major service responsibilities, regular monitoring of services and programs provided-as a follow-along service, and facilitate obtaining of needed services in cooperation with the major program delivery

agency. For the 0-25 age range the Life Consultation agency would not be the primary accountable program provider agency. This responsibility rests with the State Department of Education, and consequently, the intermediate and/or local school district would be the responsible local provider and coordinator of service. As such, the school districts would also be the prime contact point for the Life Consultation agency to obtain information regarding service delivery to a client in order to pursue its follow along responsibilities.

During these years, however, the Life Consultation Office remains a accountable for follow-along services directed toward ensuring the mobilization of all appropriate resources by the various service sources. Following age 25 or prior to age 25 if an educational program has been completed it is recommended that the Community Mental Health - Life Consultation Office continue as the one point of professional accountability for individuals. In addition, however, it is recommended that for these years Community Mental Health should assume responsibility for primary program accountability as well. This accountability should be pinpointed by statute.

Consumer Participation

The involved consumer and private agencies (for retardation, epilepsy and cerebral palsy) should continue cooperative leadership roles in promoting programs and services for the developmentally disabled.

The Michigan Association for Retarded Children and Adults (in cooperation with United Cerebral Palsy Association of Michigan) plans to establish a Citizen Advocacy Office which will develop a plan to implement local citizen advocacy groups. The state office should continue to provide leadership in the development of community offices, co-sponsoring informational regional meetings, etc.

Each of the regional inter-agency areas should plan to have an advocacy committee. The committees could play a key service monitoring role as advocates. At least the chairman would be a member of the regional inter-agency coordinating committee. The coordinator of the state advocacy program should attend Cadre meetings and also be a member of the Developmental Disabilities Advisory Council. The regional advocacy committee would relate closely with the Act 54 Life Consultation Coordinator.

Intradepartmental Quality Control and Coordinative Efforts

Gaps in service delivery due to unsuccessful coordinative efforts within departments were frequently identified in the surveys conducted. Only to the extent that Developmental Disabilities Specialists can be involved in and/or informed about established standards of excellence, evaluation of service and planning for the service delivery systems of their own departments can their input interdepartmentally be effective. Developmental Disabilities Specialist roles, currently existing within state departments need to be reviewed in terms of feasible work loads and access to policy information in the key responsibility areas noted in the Service Delivery Model which follows.

When more than one Developmental Disabilities Specialist is advising within a department, steps should be taken to carefully coordinate individual activities with the Cadre members interdepartmental responsibilities. Particular needs for additional state consultants to provide in-service education and policy leadership have been identified as including:

Agency	Service
Education	Institution-Education and Treatment Programs
Mental Health	MR Nursing Homes
Mental Health	MR Institution and Community Services Programs
Social Services	Residential Home Services (Group Homes)
Vocational Rehabilitation	Service to the severely developmentally disabled.

Developmental Disabilities Specialist positions should be established in departmental regional offices in order to facilitate in-service education of generic staff closer to the service delivery level.

Local Service Delivery Model
Life Stage: Infants (0-3)

Primary Planning Agency(s) (Interdepartmental):

State Department of Public Health
State Department of Education

Primary Program Provider Agency:

Intermediate or Local School District

Intradepartmental Quality Control:

All state level agencies noted which have a formal or semi-formal leadership relationship to the noted local service delivery agency.

Agency Responsible	Service Component
1. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program provider agency	1. Life Consultation a. Central registry. Information and referral point. b. Counseling with Consumers and/or their representatives regarding: 1. residential alternatives; 2. agency service delivery responsibilities as it might apply to their needs and obtaining of appropriate individualized programs and services. c. Follow-along - ongoing monitoring of quality of service being provided according to individualized program.
2. Various Public and Private Providers a. State Department of Education Intermediate or Local School District: Delivery of supportive services	2. Alternative Residential Component a. Parent/Relative Home
b. State Department of Social Service-County Department of Social Services: Local service delivery Liaison with primary program provider agency	b. Foster Care/Group Homes
c. State Department of Mental Health (by agreement with private contractors) State Department of Public Health (licensure only) Private Contractors and State Institutions Local service delivery Liaison with primary program provider agency	c. Nursing Homes (MR)
d. State Department of Mental Health State Institutions: Catchment area service delivery Liaison with primary program provider agency	d. Institution

Agency Responsible	Service Component
e. State Department of Mental Health-Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with primary program provider agency	e. Short term half-way houses and/or treatment residences geared for crisis intervention. Primary example being for the emotionally disturbed-mentally retarded.
3. State Department of Social Services County Department of Social Services:	3. Supportive Services Component a. Home Aids b. Transportation c. Housing d. Financial Assistance (categorical, special, medicaid, etc. e. Respite Care
e. State Department of Mental Health Act 54 Board, Community Mental Health Agency Local service delivery Liaison with primary program provider agency	
f. Same as "e"	f. Family counseling and/or specialized back-up evaluation and consultation and programming for in the home.
g. Private Agencies-Providers: Liaison with primary program provider agency	g. Specialized and/or generic back-up resources.
h. State Department of Social Services; County Department of Social Services Local service delivery Liaison with primary program provider agency	h. Protective Services
4. State Department of Public Health a. Private providers: Liaison with primary program provider agency	4. Health-Medical Component a. Physician - on-going health care and consultative input regarding maximization of educational plan by: 1. Correction of physical defects 2. Identifying of need for and/or referral for additional special therapies such as physical therapy or psychotherapy. 3. Referral for corrective devices (glasses, hearing aids, orthopedic equipment).

4. Referral for dental services.
5. Referral for specialized medical consultation.

b. State Department of Public Health County Public Health Departments:

Local service delivery
Liaison with primary program provider agency

b. Public Health nurses or specialized nursing needs.
1. Specialized counseling (direct or consultative) in regard to infant care and development, immunization, nutrition and diet, safety, clinic information for health maintenance, care of corrective appliances. Follow-up on referrals noted under "a".
2. Direct service contact for those who have on-going medical needs such as diabetes, epilepsy, etc.

c. Private Providers and/or State Department of Public Health

County Public Health Departments:

Local service delivery
Liaison with primary program provider agency

c. Generic or specialized dental and hygienist services.

d. Same as "c"

d. Specialized physical therapy and occupational therapy services.

e. Private Providers and/or consultation services of university hospitals or institutes.

e. Specialized medical consultation including psychiatric care, opthalmology, otology, etc.

f. State Department of Public Health Regional Crippled Children's Offices:

Local service delivery
Liaison with primary program provider agency

f. Crippled Childrens Services.

5. State Department of Education Intermediate or Local School District:

Local service delivery
Liaison with primary program provider agency

5. Education Component
a. On-going evaluation/diagnosis-back-up (Resources: Title VI regional centers and appropriate back-up outside resources.)
b. Educational planning and placement meeting.

Agency Responsible	Service Component
	c. Programmatic accountability assigned including for secondary handicaps. d. Appropriate home training and day programs and supportive services provided. Assessment of family unit's supportive service needs followed by referral if appropriate. e. Regular review and update of plan and program.
6. Various Providers a. State Department of Mental Health-Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program provider agency AND/OR Consumer Group Agency (such as an Advocacy unit)	6. Legal-Protective Component a. Counseling regarding general legal rights 1. Specific state or local entitlements. 2. Referral for specific legal consultation if appropriate.
b. Private providers and/or publicly funded Legal Aid Bureaus Liaison with primary program provider agency	b. Specific legal assistance of attorneys.
c. State Department of Social Services; County Department of Social Services: Local service delivery Liaison with primary program provider agency	c. Protective Services
Probate Courts Liaison with primary program provider agency	
7. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with primary program provider agency	7. Mental Health Component a. Back-up resource in area of family counseling, individual psycho-therapy, evaluation/ diagnosis, programming consultation, crisis intervention, etc.

Agency Responsible	Service Component
	b. Respite Care alternatives-including relief component and a short term treatment component.
c. State Department of Mental Health State Institutions: Catchment area service delivery Liaison with primary program provider agency	c. Back-up institutional resource as occurring in the event of crisis and for such needs as those which might be involved in the mentally ill-retarded person. Specialized diagnostic services.
8. Private Providers and/or Public Agencies such as City Recreation Departments. Liaison with primary program provider agency	8. Social-Recreational Component a. Generic-recreational activities as age readiness is apparent. b. Specialized outside the home activity centers such as through the YM and YWCA, Easter Seals, etc.
9. Private Providers Liaison with primary program provider agency	9. Religious Nurture

Local Service Delivery Model
Life Stage: Preschool (ages 3-5) and Childhood (ages 6-12) and Adolescence (ages 13-18)

Primary Planning Agency (Interdepartmental):

State Department of Education

Primary Program Provider Agency:

Intermediate or Local School District

Intradepartmental Quality Control:

All state level agencies noted which have a formal or semi-formal leadership relationship to the noted local service delivery agency.

Agency Responsible	Service Component
1. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program provider agency	1. Life Consultation a. Central registry. Information and referral point. b. Counseling with Consumers and/or their representatives regarding: 1. residential alternatives;

Agency Responsible	Service Component
	2. agency service delivery responsibilities as it might apply to their needs and obtaining of appropriate individualized programs and services. c. Follow-along - ongoing monitoring of quality of service being provided according to individualized program.
2. Various Public and Private Providers a. State Department of Education Intermediate or Local School District: Delivery of supportive services	2. Alternative Residential Component a. Parent/Relative Home
b. State Department of Social Service County Department of Social Services: Local service delivery Liaison with primary program provider agency	b. Foster Care/Group Homes
c. State Department of Mental Health (by agreement with private contractors) State Department of Public Health (licensure only) Private Contractors & State Institutions Local service delivery Liaison with primary program provider agency	c. Nursing Homes (MR)
d. State Department of Mental Health State Institutions: Catchment area service delivery Liaison with primary program provider agency	d. Institution
e. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with primary program provider agency	e. Short term half-way houses and/or treatment residences geared for crisis intervention. Primary example being for the emotionally disturbed-mentally retarded.

Agency Responsible	Service Component
3. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program provider agency	3. Supportive Services Component a. Home Aids b. Transportation c. Housing d. Financial Assistance (categorical, special, medicaid, etc.)
e. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with primary program provider agency	e. Respite Care
f. Same as "e"	f. Family counseling and/or specialized back-up evaluation and consultation and programming for in the home.
g. Private Agencies-Providers: Liaison with primary program provider agency	g. Specialized and/or generic back-up resources.
h. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program provider agency	h. Protective Services
4. State Department of Public Health a. Private providers: Liaison with primary program provider agency	4. Health-Medical Component a. Physician - on-going health care and consultative input regarding maximization of educational plan by: 1. Correction of physical defects. 2. Identifying of need for and/or referral for additional special therapies such as physical therapy or psychotherapy. 3. Referral for corrective devices (glasses, hearing aids, orthopedic equipment.) 4. Referral for dental services. 5. Referral for specialized medical consultation. 6. Referral for family planning services if appropriate.

Agency Responsible	Service Component
b. State Department of Public Health County Public Health Departments: Local service delivery Liaison with primary program provider agency	b. Public Health nurses or specialized nursing needs. 1. Specialized counseling (direct or consultative) in regard to nutrition and diet, health habits, safety, clinic information for health maintenance, care of corrective appliances. Follow up on referrals noted under "a". 2. Direct service contact for those who have on-going medical needs such as diabetes, epilepsy, etc.
c. Private Providers and/or State Department of Public Health County Public Health Departments: Local service delivery Liaison with primary program provider agency	c. Generic or specialized dental and hygienist services.
d. Same as "c"	d. Specialized physical therapy and occupational therapy services.
e. Private Providers and/or consultation services of university hospitals or institutes.	e. Specialized medical consultation including psychiatric care, opthalmology, otology, etc.
f. State Department of Public Health Regional Crippled Children's Offices: Local service delivery Liaison with primary program provider agency	f. Crippled Childrens Services
5. State Department of Education Intermediate or Local School District: Local service delivery Liaison with primary program provider agency	5. Education Component a. On-going evaluation/diagnosis - (back-up Resources: Title VI regional centers and appropriate outside resources.) b. Educational planning and placement meeting. c. Programmatic accountability assigned including for secondary handicaps. d. Appropriate day programs/ services and personnel provided. e. Regular review and update of plan and program.

Agency Responsible	Service Component
6. Various Providers	6. Legal-Protective Component
a. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program provider agency	a. Counseling regarding general legal rights 1. Specific state or local entitlements. 2. Referral for specific legal consultation if appropriate.
AND/OR	
Consumer Group Agency (such as an Advocacy unit)	
b. Private providers and/or publicaly funded Legal Aid Bureaus Liaison with primary program provider agency	b. Specific legal assistance of attorneys.
c. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program provider agency	c. Protective Services
Probate Courts Liaison with primary program provider agency	
7. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with primary program provider agency	7. Mental Health Component a. Back-up resource in area of family counseling, individual psycho-therapy, evaluation/ diagnosis, programming consultation, crisis intervention, etc. b. Respite Care alternatives - including relief component and a short term treatment component.
c. State Department of Mental Health State Institutions: Catchment area service delivery Liaison with primary program provider agency	c. Back-up institutional resource as occurring in the event of crisis and for such needs as those which might be involved in the mentally ill-retarded person. Specialized diagnostic services.

Agency Responsible	Service Component
8. Private Providers and/or Public Agencies such as City Recreation Departments. Liaison with primary program provider agency	8. Social-Recreational Component a. Generic-recreational activities. b. Specialized outside the home activity centers such as through the YM and YWCA, Easter Seals, etc.
9. Private Providers Liaison with primary program provider agency	9. Religious Nurture

Local Service Delivery Model
Life Stage: Young Adults (Approximately 19-30)

Primary Planner Agency(s) (Interdepartmental):

State Department of Education (including the Division of Vocational Rehabilitation after age 25 or prior to age 25 if educational program has been completed).
State Department of Mental Health

Primary Program Accountable Agency:

Act 54 Community Mental Health Board (with clarification that this is delegated to the State Department of Education prior to age 25 if the client is in an educational program.)

Intradepartmental Quality Control:

All state level agencies noted which have a formal or semi-formal leadership relationship to the noted local service delivery agency.

Agency Responsible	Service Component
1. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program accountable agency	1. Life Consultation a. Central Registry. Information and referral point. b. Counseling with Consumers and/or their representatives regarding: 1. residential alternatives; 2. agency service delivery responsibilities as it might apply to their needs and obtaining of appropriate individualized programs and services. c. Follow-along - on-going monitoring of quality of service being provided according to individualized program.

Agency Responsible	Service Component
	d. Primary program accountable agency responsible for acquiring appropriate program after age 25 or prior to age 25 if educational program has been completed.
2. Various Public and Private Providers a/b. Prior to age 25 - in additional placement - State Department of Education Intermediate or local school district: Delivery of supportive services State Department of Social Services County Department of Social Services: Delivery of social supportive services Liaison with primary program accountable agency After age 25 - or upon completion of educational program. State Department of Education Division of Vocational Rehabilitation Local DVR services Delivery of supportive services Liaison with primary program accountable agency AND State Department of Social Services County Department of Social Services: Delivery of supportive services Liaison with primary program accountable agency AND/OR State Department of Mental Health Act 54 Board; Community Mental Health Agency Local delivery of supportive services Liaison with primary program accountable agency	2. Alternative Residential Component a. Independent living b. Parent/relative home

Agency Responsible	Service Component
c. State Department of Social Services County Department of Social Services:	c. Foster care/group homes. These homes would provide a continuum of residential alternatives which could be sequenced from very well protected living environments to semi-dependent and possibly independent (no resident supervision) living environments.
d. State Department of Mental Health (by agreement with private providers) State Department of Public Health (licensure only) Private Contractors & State Institutions	d. Nursing Homes (MR)
e. State Department of Mental Health State Institutions:	e. Institution
f. State Department of Mental Health Act 54 Board; Community Mental Health Agency:	f. Short term half-way houses and/or treatment residences geared for crisis intervention. Primary example being for the emotionally disturbed-mentally retarded.
3. State Department of Social Services County Department of Social Services.	3. Supportive Services Component a. Home aids b. Transportation c. Housing d. Financial assistance (categorical, special, medicaid, etc.)
e. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with primary program accountable agency	e. Respite Care

Agency Responsible	Service Component
f. Same as "e"	f. Family Counseling and/or specialized back-up evaluation or consultation for in-the-home programming.
g. Private agency providers: Liaison with primary program accountable agency	g. Specialized and/or generic back-up resources.
h. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency	h. Protective Services
4. State Department of Public Health	4. Health-Medical Component
a. Private providers Liaison with primary program accountable agency	a. Physician - on-going health care and consultative input regarding maximization of service plan by: 1. Correction of physical defects. 2. Identifying of need for and/or referral for additional special therapies such as physical therapy or psycho-therapy. 3. Referral for corrective devices (glasses, hearing aids, orthopedic equipment, etc. 4. Referral for dental services. 5. Referral for specialized medical consultation. 6. Referral for family planning services.
b. State Department of Public Health County Public Health Departments: Local service delivery Liaison with primary program accountable agency	b. Public Health nurses or specialized nursing needs. 1. Specialized counseling, (direct or consultative) nutrition and diet, health habits, safety, clinic information for health maintenance, care of corrective appliances. Sex education and family planning referral. Follow up on referrals noted under "a".

Agency Responsible	Service Component
c. Private providers: State Department of Public Health County Public Health Departments: Local service delivery Liaison with primary program accountable agency	c. Generic or specialized dental hygientist services.
d. Same as "c"	d. Specialized physical therapy and occupational therapy services.
e. Private providers and/or consultation services of university hospitals or institutes. Liaison with primary program accountable agency	e. Specialized medical consultation including psychiatric care, opthalmology, otology, neurological, etc.
f. State Department of Public Health Regional Crippled Children's Offices: Local service delivery Liaison with primary program accountable agency	f. Crippled Children's Services (through age 21)
5. State Department of Education (prior to age 25) Intermediate or Local School District: Local service delivery Liaison with primary program accountable agency	5. Education-Work Training/Activity Component a. On-going evaluations/diagnosis, (Back up resources; Title VI regional centers, community mental health and vocational rehabilitation) b. Individualized program and placement appropriateness determined. c. Appropriate day program and services provided (preferably outside of residence with socialization and/or recreational component incorporated). d. Appropriate program and supportive personnel assigned. e. Regular review and update of plan and program.
OR	
(After age 25 or completion of educational program) State Department of Education Division of Vocational Rehabilitation Local DVR Services: Local service delivery Liaison with primary program accountable agency	
State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with primary program accountable agency	

Agency Responsible	Service Component
6. Various Providers	6. Legal-Protective Component
a. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program accountable agency AND/OR Consumer Group Agency (such as an Advocacy unit)	a. Counseling regarding general legal rights. 1. Specific state or local program entitlements. 2. Referral for specific legal consultation if appropriate.
b. Private providers and/or publicaly funded Legal Aid Bureaus Liaison with primary program accountable agency Probate Court Liaison with primary program accountable agency	b. Specific legal assistance of attorneys.
c. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency	c. Protective Services
7. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with primary program accountable agency	7. Mental Health Component a. Provision of Day Programming opportunities including day activity centers with work activity and social-recreational components. b. Follow-along services as appropriate to day programs. c. Back-up resource in the area of family counseling individual psycho-therapy, evaluation/diagnosis, programming consultation, crisis intervention, etc. d. Respite Care Alternatives - including relief component and a short term treatment component.
e. State Department of Mental Health State Institutions: Catchment area service delivery Liaison with primary program accountable agency	e. Back-up institutional resource as occurring in the event of crisis and for such needs as those necessary for the mentally ill-retarded person. Specialized diagnostic services.

Agency Responsible	Service Component
8. Private providers. AND/OR State Department of Mental Health Act 54 Board; Community Mental Health Agency OR State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency OR Public Agencies such as City Recreation Departments Liaison with primary program accountable agency	8. Social-Recreational Component a. Outside the residence Adult Activity Centers with socio-recreational component. b. Generic or specialized recreation opportunities through the YM and YWCA, Easter Seal, etc. c. In-residence social-recreation programming.
9. Private Providers Liaison with primary program accountable agency	9. Religious Nurture

Local Service Delivery Model
Life Stage: Adult Years (Approximately 31-64)

Primary Planner Agency(s) (Interdepartmental):

State Department of Mental Health and
State Department of Social Services

Primary Program Accountable Agency:

Act 54 Board; Community Mental Health Board - (Responsible for monitoring and acquiring appropriate program delivery by the responsible agencies.)

Intradepartmental Quality Control:

All State Level Agencies noted which have a formal or semi-formal leadership relationship to the noted local service delivery agency.

Agency Responsible	Service Component
1. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program accountable agency	1. Life Consultation a. Central registry, Information and referral point. b. Counseling with Consumers and/or their representatives regarding individual needs.

Agency Responsible	Service Component
	c. Follow-along - ongoing monitoring of quality of service being provided according to individualized program.
	d. Primary responsibility for acquiring appropriate program from legally responsible agencies.
2. Various Public and Private Providers	2. Alternative Residential Component
a. State Department of Social Services County Department of Social Services: Delivery of social supportive services. Liaison with primary program accountable agency.	a. Independent living arrangement.
b. Same as "a"	b. Parent/Relative Home
c. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency.	c. Foster Care/group homes. These homes would provide a continuum of residential alternatives which could be sequences from very well protected living environments to semi-dependent and possibly independent (no resident supervision) living environments.
d. State Department of Mental Health (by agreement with private providers) State Department of Public Health (licensure only) Private contractors and State Institutions: Local service delivery Liaison with primary program accountable agency.	d. Nursing Homes (MR)
e. State Department of Mental Health State Institutions: Catchment area service delivery Liaison with primary program accountable agency.	e. Institution

Agency Responsible	Service Component
f. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with its program monitoring agency	f. Short term half-way houses and/or treatment residences geared for crisis intervention. Primary example being for the emotionally disturbed-mentally retarded.
g. Private Providers and/or possible federally funded projects	g. Housing developments for senior citizens and/or those retired living on disability incomes.
State Department of Social Services County Department of Social Services: Delivery of social supportive services. Liaison with primary program accountable agency.	
3. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency.	3. Supportive Services Component a. Home aids b. Special Transportation Services c. Housing d. Financial assistance (categorical, special, medicaid, etc.) e. Respite Care
e. State Department of Mental Health Act 54; Community Mental Health Agency: Local service delivery Liaison with its program monitoring agency	
f. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery	f. Family Counseling and/or specialized back-up evaluation or consultation for in-the-home programming.
g. Private agency providers: Liaison with primary program accountable agency.	g. Specialized and/or generic back-up resources.
h. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency.	h. Protective Services

Agency Responsible	Service Component
i. Office of Services to the Aging-Area Agencies: Local service delivery Liaison with primary program accountable agency.	i. As approaching age 65 - Specialized senior citizen services under Titles III and VII of the Older Americans Act.
4. State Department of Public Health	4. Health-Medical Component
a. Private providers: Liaison with primary program accountable agency.	a. Physician - on-going health care and consultative input regarding maximization of service plan by: 1. Correction of physical defects 2. Identifying of need for and/or referral for additional special therapies such as physical therapy or psycho-therapy. 3. Referral for corrective devices (glasses, hearing aides, orthopedic equipment, etc.) 4. Referral for dental services. 5. Referral for specialized medical consultation. 6. Referral for family planning services.
b. State Department of Public Health County Department of Public Health Local service delivery Liaison with primary program accountable agency.	b. Public Health nurses or specialized nursing needs. 1. Counseling specialized (direct or consultative) in regard to nutrition and diet, health habits, safety, clinic information for health maintenance, care of corrective appliances. Sex education and family planning referral. Follow up on referrals noted under "a". 2. Direct service contact for those who have on-going medical needs such as diabetes, epilepsy, etc.

Agency Responsible	Service Component
c. Private Providers and/or State Department of Public Health County Health Departments: Local service delivery Liaison with primary program accountable agency	c. Generic or specialized dental and hygienist services
d. Same as "c"	d. Specialized physical therapy and occupationsl therapy services.
e. Private provider and/or consultation services of university hospitals or institutes: Liaison with primary program accountable agency	e. Specialized medical consultation including psychiatric care, opthalmology, otology, neurological, etc.
5. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with its program monitoring agency AND/OR State Department of Education Division of Vocational Rehabilitation: Local Sheltered Workshops or activity programs. Service delivery agency Liaison with primary program accountable agency	5. Employment-Work Activity Component a. On-going diagnosis/evaluation (Back-up resource of CMH and institutions and vocational rehabilitation as diagnostic centers.) b. Individualized program and placement appropriateness determined. c. Appropriate day program with graded sequence of work related or employment opportunities provided outside of residence if at all possible. Socialization component to be incorporated. d. Appropriate supportive personnel assigned. e. Regular review and update of plan and program.
6. Various Providers a. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program accountable agency AND/OR Consumer Group Agency (such as an Advocacy unit.)	6. Legal-Protective Component a. Counseling regarding general legal rights. 1. Specific state or local program entitlements. 2. Referral for specific legal consultation if appropriate.

Agency Responsible	Service Component
b. Private Provider and/or publicly funded Legal Aid Bureaus.	b. Specific legal assistance of attorneys.
c. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency Probate Courts Liaison with primary program accountable agency	c. Protective Services
7. State Department of Mental Health Act 54 Board; Community Mental Health Agencies: Local service delivery Liaison with its program monitoring agency	7. Mental Health Component a. Provision of Day Programming opportunities including day activity centers with work activity components and social-recreational component. b. Alternative and back-up resource to private providers in the area of family counseling, individual psychotherapy, evaluation/diagnosis, programming consultation, crisis intervention, etc. c. Respite Care Alternatives - including relief component and a short term treatment component.
d. State Department of Mental Health State Institutions: Catchment area delivery of service Liaison with primary program accountable agency	d. Back-up institutional resource as occurring in the event of crisis and for such needs as those which might be involved in the mentally ill-retarded person. Specialized diagnostic services.
8. Private Providers - and/or Public agencies such as City Recreation Departments. AND/OR State Department of Mental Health Act 54 Board: Community Mental Health Agency:	8. Social-Recreational Component a. Outside the residence adult activity centers with socio-recreational component. b. Generic or specialized recreation opportunities through the YM and YWCA, Easter Seal, etc. c. In residence social-recreational programming.

Agency Responsible	Service Component
OR	
State Department of Social Services County Department of Social Services Liaison with primary program accountable agency.	
9. Private Providers Liaison with primary program accountable agency.	9. Religious Nurture

Local Service Delivery Model
Life Stage: Elderly (Age 65+)

Primary Planner Agency (Interdepartmental):

Department of Social Services in cooperation with the Office of Services to the Aging.

Primary Program Accountable Agency:

Act 54 Board; Community Mental Health Board - (Responsible for monitoring and acquiring appropriate program delivery by the statutorally responsible agencies.

Intradepartmental Quality Control:

All State Level Agencies in a formal or semi-formal leadership relationship to the noted local service delivery agency.

Agency Responsible	Service Component
1. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with primary program accountable agency	1. Life Consultation a. Central registry. Information and referral point. b. Counseling with Consumers and/or their representatives regarding: 1. residential alternatives; 2. agency service delivery responsibilities as it might apply to their needs and obtaining of appropriate individualized programs and services.

c. Follow-along - on-going monitoring of quality of service being provided according to individualized program.
d. Primary responsibility for acquiring appropriate program from statutorally responsible agencies.

2. Various Public and Private Providers

a. State Department of Social Services

County Department of Social Services:

Delivery of social supportive services.
Liaison with primary program accountable agency

2. Alternative Residential Component

a. Independent living arrangement.

b. Same as "a"

b. Relative Home

c. State Department of Social Services

County Department of Social Services:

Local service delivery
Liaison with primary program accountable agency.

c. Foster Care/group homes. These homes would provide a continuum of residential alternatives which could be sequenced from very well protected living environments to semi-dependent and possibly independent (no resident supervision) living environments.

d. State Department of Mental Health (by agreement with private providers)

State Department of Public Health (licensure only)

Private contractors and State Institutions:

Local service delivery
Liaison with primary program accountable agency.

d. Nursing Homes (MR)

e. State Department of Mental Health

State Institutions:

Catchment area service delivery agency
Liaison with primary program accountable agency

e. Institution

Agency Responsible	Service Component
f. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with its program monitoring agency	f. Short term half-way houses and/or treatment residences geared for crisis intervention. Primary example being for the emotionally disturbed-mentally retarded.
g. Private Providers and/or possible federally funded projects	g. Housing developments for senior citizens and/or those retired living on disability incomes.
State Department of Social Services County Department of Social Services: Delivery of social supportive services. Liaison with primary program accountable agency.	
3. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency	3. Supportive Services Component a. Home aids b. Special Transportation Services c. Housing d. Financial assistance (categorical, special, medicare, etc.)
e. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with its program monitoring agency	e. Respite Care
f. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery	f. Family Counseling and/or specialized back-up evaluation or consultation for in-the-home programming.
g. Private agency providers: Liaison with primary program accountable agency	g. Specialized and/or generic back-up resources.
h. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency	h. Protective Services

Agency Responsible	Service Component
i. Office of Services to the Aging Area Agencies: Local service delivery Liaison with primary program accountable agency	i. Specialized senior citizen services under Titles III and VII of the Older Americans Act.
4. State Department of Public Health	4. Health-Medical Component
a. Private providers: Liaison with primary program accountable agency	a. Physician - on-going health care and consultative input regarding maximization of service plan by: 1. Correction of physical defects 2. Identifying of need for and/or referral for additional special therapies such as physical therapy or psycho-therapy. 3. Referral for corrective devices (glasses, hearing aids, orthopedic equipment, etc.) 4. Referral for dental services. 5. Referral for specialized medical consultation.
b. State Department of Public Health County Department of Public Health Local service delivery Liaison with primary program accountable agency	b. Public Health nurses or specialized nursing needs. 1. Specialized counseling (direct or consultative) in regard to nutrition and diet, health maintenance, safety, utilization of individual medical prescriptions. Follow-up on referrals noted under "a". 2. Direct service contact for those who have on-going medical needs such as diabetes, epilepsy, etc. Specialized nursing care for those with aging-related medical needs.

Agency Responsible	Service Component
c. Private Providers and/or State Department of Public Health County Health Departments: Local service delivery Liaison with primary program accountable agency	c. Generic or specialized dental and hygienist services
d. Same as "c"	d. Specialized physical therapy and occupational therapy services.
e. Private provider and/or consultation services of university hospitals or institutes: Liaison with primary program accountable agency	e. Specialized medical consultation including psychiatric care, optholmology, otology, neurological, etc.
5. State Department of Mental Health Act 54 Board; Community Mental Health Agency: Local service delivery Liaison with its program monitoring agency	5. Employment-Work Activity Component a. On-going diagnosis/evaluation. (Back-up resources of CMH, institutions and voc. rehab. for evaluative services.) b. Individualized program and placement appropriateness determined. c. Appropriate day program provided outside of residence if at all possible. Socialization component to be incorporated. d. Appropriate supportive personnel assigned. e. Regular review and update of plan and program.
AND/OR State Department of Education Division of Vocational Rehabilitation Local DVR Services: Local service delivery Liaison with primary program accountable agency	
6. Various Providers a. State Department of Mental Health Act 54 Board; Life Consultation Office: Local service delivery Liaison with its program monitoring agency	6. Legal-Protective Component a. Counseling regarding general legal rights. 1. Specific state or local program entitlements. 2. Referral for specific legal consultation if appropriate.
AND/OR Consumer Group Agency (such as an Advocacy unit.)	

Agency Responsible	Service Component
b. Private Provider and/or publicly funded Legal Aid Bureaus.	b. Specific legal assistance of attorneys.
c. State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency	c. Protective Services
Probate Courts Liaison with primary program accountable agency	
7. State Department of Mental Health Act 54 Board; Community Mental Health Agencies: Local service delivery Liaison with its program monitoring agency	7. Mental Health Component a. Provision of Day Programming opportunities including day activity centers with work activity components and social-recreational component. (This would be as a programming alternative to Senior Citizen programs.) b. Alternative and back-up resource to private providers in the area of family counseling, individual psycho-therapy, evaluation/diagnosis, programming consultation, crisis intervention, etc. c. Respite Care Alternatives - including relief component and a short term treatment component.
d. State Department of Mental Health State Institutions: Catchment area delivery of service Liaison with primary program accountable agency	d. Back-up institutional resource as occurring in the event of crisis and for such needs as those which might be involved in the mentally ill-retarded person. Specialized diagnostic services.
8. Private Providers. AND/OR State Department of Mental Health Act 54 Board; Community Mental Health Agency: OR	

Agency Responsible	Service Component
Offices of Services to the Aging Area agency coordinated programs: OR State Department of Social Services County Department of Social Services: Local service delivery Liaison with primary program accountable agency Private Providers and/or Public Agencies such as City Recreation Departments Liaison with primary program accountable agency	8. Social-Recreational Component a. Outside the residence adult activity centers with socio-recreational component. b. Generic or specialized recreation opportunities through the YM and YWCA, Easter Seal, etc. c. In residence social-recreational programming.
9. Private Providers. Liaison with primary program accountable agency	9. Religious Nurture

SELECTED REFERENCES

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Harris, Gail A., Ed.D., A Guide to Services for the Mentally Retarded in Michigan. Lansing: Michigan Association for Retarded Children and Adults, 1974.

Joint Commission on Accreditation of Hospitals. Accreditation Council for Facilities for the Mentally Retarded. Standards for Community Agencies. Chicago, Illinois, 1973.

Joint Commission on Accreditation of Hospitals. Accreditation Council for Facilities for the Mentally Retarded. Standards for Residential Facilities for the Mentally Retarded. Chicago, Illinois, 1971.

Kugel, Robert and Wolfensberger, Wolf, Changing Patterns in Residential Services for the Mentally Retarded. President's Committee on Mental Retardation, Washington, D.C., 1/10/1969.

State of Michigan. Community Placement Program: A Report from the Office of Health and Medical Affairs. Lansing, February, 1974.

State of Michigan. Fiscal Year 1974, State Plan, Developmental Disabilities Services and Facilities Construction Act of 1970. Lansing: Department of Public Health, 1974.

State of Michigan. State Department Plans - by Agency and Selected Divisions.

The American Association On Mental Deficiency. Standards for State Residential Institutions for the Mentally Retarded. A Monograph Supplement. Vol. 68, No. 4. Albany, New York: The American Association on Mental Deficiency, 1964.

APPENDIX A

National Significance Project for Michigan
INSTITUTION SURVEY

PART I. ADMINISTRATIVE INTERVIEW GUIDE
SURVEY AREA: RESIDENT CHARACTERISTICS AND PROGRAM NEEDS

(Refer to descriptive data sheet(s) for particular institution--shared ahead of time--regarding what population(s) is being served, programs in effect, staff-ratios, etc.)

1. What are the major factors determining why these particular residents are in the institution as opposed to an alternate placement?

   Some Possible Responses

   _____a) Multiple involvements
   _____b) Community alternatives not available
   _____c) 24 hr. medical needs
   _____d) Severe behavior problem

(Note comparison with frequency ranking from central office in regard to: etiological codes and programs currently needed - special and regular.)

2. If the factors you mentioned in question one could be resolved, could the habilitative needs of these residents be better met by a placement in the community?

   _____ Yes _____ No

3. How is your institution currently meeting the program needs of the residents? (Consider staffing pattern, accountability, etc.)

4. What needs to be done to change your physical plant and program structure so that the normalization principle might be better promoted?

5. What should be the appropriate role of the institution in serving the mentally retarded population?

   a) Are there particular population types it should serve? Such as:

   Some Possible Responses

   _____ All with I.Q.'s below 30
   _____ 24 hr. medical care
   _____ Multiply handicapped
   _____ Those with intensive time-limited service needs
   _____ Behavioral problems

b) Should it be available as a placement of last resort for all of the retarded?

_____ Yes _____ No

c) Should different institutions serve specialized functions rather than providing all programs?

_____ Yes _____ No

6. Please identify some of your major concerns related to appropriateness of programming for your resident's service needs?

Have you implemented some changes related to these concerns? (Cite responses to Accreditation Standards)

_____ Yes _____ No

7. Has your staff gone through the self survey to acquaint themselves with Accreditation Standards?

_____ Yes _____No

8. For what kinds of service needs are you planning to use MR nursing homes?

9. Do you have a written, distributed policy regarding the legal rights of residents and their families?

_____ Yes _____ No

What specific difficulties have you noted particularly in regard to guardianship vs. advocacy?

10. What do you envision as the ideal mechanism for referral, evaluation and intake into the service delivery system for the developmentally disabled?

11. Given the creation of the new Human Services Department what do you feel would be appropriate assignments of responsibility to the various merged professionals? (Specifically in regard to servicing the developmentally disabled.)

12. What types of new legislation are needed to better service the developmentally disabled?

13. Have you had any difficulties with job classifications as specified by Civil Service? If so, what kinds of problems at what levels of classification?

_____ Yes _____ No

a) Would you recommend any new classifications or changes in the current ones? What would these recommendations be?

_____ Yes _____ No

b) Do you feel there are appropriate roles for two year Associate degreed personnel (i.e., paraprofessionals) in your programs? If "yes", what are these roles?

_____ Yes _____ No

14. If you had all necessary resources to create "ideal" programs for your residents what kind of service system would you establish?

SURVEY AREA: RESEARCH AND PROGRAM EVALUATION

1. Do you have a research and evaluation component at your institution? If "Yes" explain its structure and input into planning and policy development.

_____ Yes _____ No

2. Is regular data reporting provided by central office back to your institution? If "Yes", how do you utilize this information?

_____ Yes _____ No

3. What in your opinion is the most useful function that universities can perform in relation to the institution?

Some Possibilities (Check)

_____a) Research to develop new technologies of direct intervention
_____b) Research to develop new technologies of service management and delivery
_____c) Provision of extra staff
_____d) Providing evaluative feedback
_____e) Providing clinical support services
_____f) Prevention research in such areas as genetics, chemistry, environmental design, etc.
_____g) Curriculum changes for training new entrants into the professions

4. Do you have a formally defined process by which parents and volunteers can have input into program evaluation and/or policy development?

If "yes", what is that process? _____ Yes _____ No

5. Will you apply the residential facilities accreditation standards to the nursing homes in your catchment area?

_____ Yes _____ No

6. How do changes get started most frequently at your institution?

Some Possibilities (Check)

_____ State Department of Mental Health initiative
_____ Other governmental changes such as new laws affecting funding
_____ Institution administrative staff
_____ Institution professional staff
_____ Institution non-professional staff
_____ Residents and their relatives or parent associations
_____ Volunteers
_____ Outside institutions having frequent contact such as universities, community agencies, etc.
_____ Your own program evaluation unit
_____ Other (Please specify)

7. What is the most appropriate method of providing in-service training at your facility, given who it serves, where it is located and the staffing patterns utilized?

SURVEY AREA: SUPPORTIVE SERVICES

1. How are the needs for vision, auditory, dental and orthopedic screening met now at your institution?

2. What is the feasibility of the institution serving as a service base for once a year recall for the above screening and/or clinic service delivery?

PART II. PROGRAM DIRECTOR/SUPERVISOR STAFF SURVEY
SURVEY AREA: MULTIPLE HANDICAPS

A. ORTHOPEDIC AND MULTIPLE PHYSICAL HANDICAPS

YES	NO		
___	___	1.	Are body positioning procedures and splints or other corrective devices used to prevent secondary deformities?
___	___	2.	Do multi-handicapped residents spend a major portion of the day out of bed?
___	___	3.	Is positional balance and gross motor coordination encouraged through floor mat activities, ambulators and appropriately fitted wheelchairs?
___	___	4.	Are a variety of techniques used to develop head control and sitting balance?

YES NO

___ ___ 5. Is the environment structured to promote crawling, creeping, rolling, pulling erect and strengthening of trunk muscles?

___ ___ 6. Is the living environment conducive to ambulation and other forms of locomotion?

___ ___ 7. Are straps, bars, ramps and supports used to promote independent use of living unit facilities by residents in wheelchairs?

___ ___ 8. Do wheelchairs fit the body size and physical characteristics of residents?

___ ___ 9. Are prosthetic and assistive aids used to maximize the educational and work capabilities of multi-handicapped residents?

___ ___ 10. Have direct care staff been trained in how to use and adjust prosthetic devices for residents with multiple problems?

B. EPILEPSY

___ ___ 1. Are records available which indicate regular medication review?

___ ___ 2. Have personnel been trained in the procedures to be followed when residents have seizures?

___ ___ 3. Are epileptic residents allowed full participation in training, social and recreational activities afforded non-epileptic residents?

C. VISUAL IMPAIRMENT

___ ___ 1. Are visually impaired residents allowed to live with sighted residents of comparable age and ability level?

___ ___ 2. Is the living unit arranged and furnished so as to increase the mobility and self-care functions of visually impaired residents?

___ ___ 3. Have all identified visually impaired residents who can benefit from glasses been fitted and trained to wear them?

___ ___ 4. Are special sensory training and mobility programs available for blind residents to supplement other residential training programs?

YES NO

___ ___ 5. Are mobility programs for blind residents designed to increasingly encourage independent travel, both in the institution and in the community?

D. HEARING.DISABILITY

___ ___ 1. Are hearing impaired residents provided a living environment which will promote normal patterns of daily living?

___ ___ 2. Are manual and oral communication methods used according to individual resident needs?

___ ___ 3. Do the individualized habilitative programs of hearing impaired residents include specific recommendations for auditory stimulation and communication training?

___ ___ 4. Are a variety of amplification devices available to hearing impaired residents?

___ ___ 5. Are direct care staff persons trained to do questions three and four (3 and 4) above?

E. STAFF TECHNIQUE

___ ___ 1. Are all staff persons having contact with multiply handicapped residents knowledgeable of and able to use behavior shaping principles to increase resident adaptation to and usage of prosthetic devices?

PART III. PROGRAM DIRECTOR/SUPERVISOR INTERVIEW GUIDE
SURVEY AREA: HABILITATIVE PROGRAMMING

YES NO

___ ___ 1. Are there individualized objectives and plans for all residents?

___ ___ For all programs?

___ ___ 2. Are plans and objectives specific enough so as to yield measureable results?

___ ___ 3. Are all staff aware of the plans and objectives for each resident?

___ ___ a) Are they physically available for at least daily reference by all direct care staff?

YES NO

___ ___ 4. Does the plan include strategies for meeting objectives in all developmental areas?

___ ___ 5. Is the individualized plan appropriate, i.e., does it address the reason(s) for referral, special programming needs, age needs, etc.?

6. What are the role definitions of your various professional staff? Are they utilized by skill areas (cross modality) or by specific definitions of tasks?

7. How are professional staff assigned responsibilities? (Is it by departmental role definitions or by team assignments to a particular number of residents?) If by teams, who constitutes the team?

___ ___ 8. Are the teams held accountable as a team for producing individualized habilitative plans, implementation of strategies, review and measurements of progress? What is the accountability mechanism?

9. Where do the persons on the team spend most of their day in relation to the residents they are serving?

10. What is the appropriate role of parents and residents in designing their programs?

___ ___ 11. Are achievement criteria, rather than age or length of time at a given level, utilized for movement within and out of the institution?

12. How does the Adult Activity Program differ programmatically for 21 year olds and 50 year olds?

13. How are volunteers trained, supervised and held accountable?

14. What are some of the in-service needs of your staff? (Needed content in-put)

    a) What has been the most valuable type of in-service training attempted? Why?

15. What are some new things you have tried programmatically that have been particularly successful?

16. If you had all the resources that you might need to construct "ideal" programs for your developmentally disabled residents, what kind of system of services would you provide?

PART IV. ATTENDANT STAFF SURVEY
(CONFIDENTIAL)
(Each section distributed separately.)

1. How many residents do you directly service daily (on the average)?
   a) How many other Attendant Nurses also serve these residents when you do?
   b) What is the most important thing you do with them?
   c) Why do you consider this to be most important?
2. How many residents do you feel are capable of doing better than they are doing in at least one self care task?
3. What is needed to help them do better?
4. What other programs does your group go to? (e.g., School?)

---

1. Do you feel any of the residents you serve will ever leave the institution and reside in the community? Which type of resident might this be?
2. What, in your opinion, is the primary reason released residents are returned to the institution after they have once left. Please check:

   _____ Were not ready to leave in the first place
   _____ For respite care (short term) at the institution
   _____ Behavior problem
   _____ Medical crisis
   _____ Family crisis
   _____ Other (please specify)

3. What things do your residents do during the day which are not like a normal routine?
   a) What physical features in your ward could be made more like the normal?

---

1. What is the professional training of the supervisory person you respect most? Please check:

   _____Nurse
   _____Teacher
   _____Social Worker
   _____Psychologist
   _____Doctor
   _____Activities Therapist
   _____Non-Professional Volunteer
   _____Other

   a) Why do you respect that person the most?
2. How should parents be involved in ward activities with you and the resident?

3. What about volunteer help - what could they do?

4. Have you received instruction on how to use and adjust prosthetic devices for residents with multiple problems? (Example, hearing aids, glasses, wheel chairs, headboards with straps)

   a) Do you feel confident in helping such residents?

---

1. Have you participated in an in-service training program during the past year?

   _____ Yes _____ No

   If "yes", what way(s) was it of value or not of value to you in your daily work activity?

2. If you could change on thing in the institution what would it be and how would you change it?

PART V. OBSERVATION GUIDE

1. Do you see evidence of individualized programming and implementation of the normalization principle in the following areas:

   a) Mobility Training
   (E.g.-Can you see any residents leaving to go out to the community with staff, parents, volunteers, etc.?)

   b) Eating
   (E.g.'s-Are majority of residents being tube fed?
   -Do residents eat with staff?)

   c) Bathing
   (E.g.-Are residents allowed to touch the wash cloth and/or towel?)

   d) Dressing
   (E.g.'s-Does each resident have his own clothing?
   -Hair styles-similar to community?)

   e) Toileting
   (E.g.'s-Are there doors for privacy?
   -Toilet Training charts available?)

   f) Social Recreation
   (E.g.'s-Space, floor equipment for multiply handicapped?
   -Do all residents get to go outside all year?
   -Are appropriate play skills being taught?)

   g) Pre-Vocational or Work Training
   (What tasks are assigned? To whom? Where?)

2. As staff are involved with residents in the above activities are they talking to them and labeling clothing articles, body parts, eating utensils, etc.?

3. Does the living unit have distinct home-like areas for the above activities, which are conducive to privacy and individual living patterns?

4. Recall why these residents are here - (administrator's statement) Are these reasons (needs) being addressed?

_____ Yes _____ No

5. Recall "appropriate role of the institution." Is this what is done best here?

_____ Yes _____ No

6. Any evidence of how staff functions as teams?

_____ Yes _____ No

7. Any evidence that inter-disciplinary teams are assigned consistently to the same residents.

_____ Yes _____ No

8. Do you see students? Responses?

_____ Yes _____ No

9. Do you see parents? Responses?

_____ Yes _____ No

10. Do you see volunteers? Responses?

_____ Yes _____ No

11. Any medical screening going on?

_____ Yes _____ No

12. Do <u>records</u> indicate individualized programming, evaluation of progress and program alteration?

_____ Yes _____ No

13. Evidence of age appropriate materials presented at appropriate academic levels?

_____ Yes _____ No

14. Do nurses supervise units in which "well" residents reside?

_____ Yes _____ No

15. How is behavior control accomplished?

16. What are residents called? (e.g., - patients, students, by first name, etc.)

MICHIGAN ASSOCIATION FOR RETARDED CHILDREN AND ADULTS
SPECIAL PROJECTS
510 Michigan National Tower
Lansing, Michigan 48933
Telephone (517) 485-2647

SURVEY FOR REGIONAL INTER-AGENCY COORDINATING COMMITTEES FOR THE DEVELOPMENTALLY DISABLED

We need inter-agency planning for the national significance project for Michigan entitled: "Institutional Reform and Deinstitutionalization Plan." The project is sponsored by the Michigan Association for Retarded Children and Adults, in cooperation with the Michigan Departments of Public Health, Social Services and Mental Health. Project cooperation and follow-up implementation efforts have been indicated by the involved state agencies.

This is an opportunity for each of the 19 regional inter-agency committees to help spell-out a workable plan for this State to overcome problems in providing effective services to the developmentally disabled who are in institutions, ready to return from institutions, or at risk of being institutionalized due to lack of appropriate community services. The plan will be completed and available for distribution and implementation efforts as of July 1, 1974.

It is important that each committee respond with at least one or two items for state planning. (More items would be welcomed.) Contained herein:

The Two Survey Questions
Suggested Response Format
Background Consideration Suggestions
Time Line and Responsibility List
Institution Statistics by County

The responses should be returned by the regional committee chairman by February 1, 1974 to:

Dr. Gail A. Harris, Project Director
Michigan Association for Retarded Children and Adults
510 Michigan National Tower
Lansing, Michigan 48933

THE SURVEY QUESTIONS

1. WHAT SPECIFIC ADDITIONAL OR CHANGED SERVICES ARE NEEDED TO PREVENT UNNECESSARY INSTITUTIONALIZATION OF THE DEVELOPMENTALLY DISABLED?
2. WHAT SPECIFIC ADDITIONAL OR CHANGED SERVICES ARE NEEDED TO HELP MAKE THE RETURN OF INSTITUTION RESIDENTS TO COMMUNITY LIFE SUCCESSFUL?

SUGGESTED RESPONSE FORMAT

What the problem is.
Why the current system isn't working.
Supporting information such as statistics about numbers waiting for service.
Possible Solution(s).
Which agency should assume primary responsibility.
Additional needs such as staff, facilities, equipment, services, etc.
What is required to make this change (new legislation, regulations, policies, etc.)

BACKGROUND CONSIDERATION SUGGESTIONS

The types of needed services may include any of the following or others:

Coordination
Central Referral Services
Diagnosis & Evaluation
Home Counseling
Advocacy
Protective Services
Guardianship
Institution Release Preparation
Health Care
Dental Services
Vision & Hearing Services
Social Services
Respite Care
Other Special Services
Recreation
Religious Nurture
Education & Training
Sheltered Workshops
Home Finding
Community Residential Services
Home Management Assistance for the Adult D.D.
Public Education
In-Service Education for all service personnel
Transportation
Speech Therapy

In developing recommendations, the following materials may be helpful in your considerations:

1) Agency Statistics by Age and Disability.
2) D.D. Priority Listing for your region.
3) Numbers who had to return to the institution from community placement and the reasons for the return (i.e., medical needs, behavioral problems, home break-down, etc.)
4) Problems of those returned to community from the institution.
5) The needs of those at risk of being institutionalized.
6) What new or expanded services each agency will need to serve the numbers who may be released from institutions in the next five (5) years.
7) Special problems of the multiply-handicapped.
8) National Accreditation Standards for Community Agencies Service Persons with Mental Retardation and other Developmental Disabilities.

TIME LINE AND RESPONSIBILITY LIST

RICC's

Distribute survey (October and November).
May wish to divide region for issue development.
Each member to discuss with own agency.
Discuss at RICC meeting (December) - May wish to invite Cadre resource or project staff.
Finalize RICC recommendations (January).
Return to Dr. Harris (by February 1, 1974).

Cadre

Participate when requested with RICC's.
After 2-1-74--Help analyze issues and discuss with agency colleagues.
Participate in MARC Inter-Agency Workshop.
Finalize Recommendations with Project Staff.

MARC

February or March, 1974 - Workshop Session.
Refine issues and recommendations as presented by RICC's.

COUNTY	TOTAL MR IN INSTITUTIONS*			ONE-THIRD RESIDENTS**	YEARLY RELEASE ESTIMATE***
	M	F	Total		
Alcona	6	1	7	2	1
Alger	10	3	13	4	1
Allegan	33	23	56	19	4
Alpena	19	14	33	11	2
Antrim	5	1	6	2	1
Arenac	8	9	17	6	1
Baroga	7	2	9	3	1
Barry	15	18	33	11	2
Bay	73	44	117	39	8
Benzie	8	6	14	5	1
Berrien	105	75	180	60	12
Branch	26	22	48	16	3
Calhoun	127	68	195	65	13
Cass	29	20	49	16	3
Charlevoix	14	9	23	8	2
Cheboygan	9	14	23	8	2
Chippewa	26	19	45	15	3
Clare	10	12	22	7	1
Clinton	22	26	48	16	3
Crawford	4	1	5	1	1

COUNTY	TOTAL MR IN INSTITUTIONS*			ONE-THIRD RESIDENTS**	YEARLY RELEASE ESTIMATE***
	M	F	Total		
Delta	25	21	46	16	3
Dickinson	16	12	28	9	2
Eaton	37	18	55	18	4
Emmet	11	14	25	8	2
Genesee	246	197	443	148	28
Gladwin	8	4	12	4	1
Gogebic	25	13	38	13	3
Grand Traverse	23	18	41	14	3
Gratiot	30	23	53	18	4
Hillsdale	48	21	69	23	5
Houghton	23	25	48	16	3
Huron	18	13	31	10	2
Ingham	128	116	244	81	16
Ionia	33	20	53	18	4
Iosco	10	6	16	5	1
Iron	7	8	15	5	1
Isabella	26	22	48	16	3
Jackson	88	67	155	51	10
Kalamazoo	99	77	176	59	12
Kalkaska	2	3	5	1	1
Kent	195	132	327	109	21
Keweenaw		2	2		1
Lake	3	2	5	1	1
Lapeer	28	27	55	13	4
Leelanau	5	5	10	3	1
Lenawee	42	29	71	24	5
Livingston	25	16	41	14	3
Luce	9	4	13	4	1
Mackinac	10	8	18	6	1
Macomb	181	113	294	98	20
Manistee	12	8	20	7	1
Marquette	30	20	50	17	3
Mason	16	10	26	9	2
Mecosta	13	9	22	7	1
Menominee	18	4	22	7	1
Midland	46	28	74	25	5
Missaukee	5	4	9	3	1
Monroe	49	39	88	29	6
Montcalm	18	7	25	8	2
Montmorency	5	2	7	2	1

COUNTY	TOTAL MR IN INSTITUTIONS* M	F	Total	ONE-THIRD RESIDENTS**	YEARLY RELEASE ESTIMATE***
Muskegon	110	90	200	67	13
Newaygo	14	11	25	8	2
Oakland	316	188	504	168	34
Oceana	22	8	30	10	2
Ogemaw	3	7	10	3	1
Ontonagon	10	7	17	6	1
Osceola	9	7	16	5	1
Oscoda	5	3	8	3	1
Otsego	7	6	13	4	1
Ottawa	49	42	91	30	6
Presque Isle	8	5	13	4	1
Roscommon	8	9	17	6	1
Saginaw	151	112	263	88	18
St. Clair	66	47	113	38	8
St. Joseph	22	29	51	17	3
Sanilac	23	14	37	12	2
Schoolcraft	7	8	15	5	1
Shiawassee	32	27	59	20	4
Tuscola	33	10	43	14	3
Van Buren	23	20	43	14	3
Washtenaw	71	61	132	44	9
Wayne	1762	1278	3040	1013	204
Wexford	11	6	17	6	1
Out of State	13	6	19	6	1
Unknown	18	12	30	10	2
Total	8529			2843	569
Male	4962			1654	331
Female	3567			1189	238

*Age breakdown details and numbers by institution are available from the Michigan Department of Mental Health.

**One-third of residents is national projection for release within five (5) years.

***This is a national estimate figure shared for basic planning only. Statistics from Michigan Department of Mental Health as of July 23, 1973.

MICHIGAN ASSOCIATION FOR RETARDED CHILDREN AND ADULTS
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ADULT ACTIVITIES SURVEY

M E M O

TO: Directors of Adult Activity Centers

FROM: Dr. Gail A. Harris, Project Director

RE: Waiting List Numbers

DATE: March 21, 1974

We need some hard-core data about numbers wainting for adult activity centers for our state plan project in order to request adequate funding and leadership provisions to meet those needs.

Could you please send us the following information by return mail.

Name of Center _____

Number of Spaces for Clients _____

Actual Number of Clients _____

Known number of persons waiting for this program _____

Waiting List	Number
In community program now	_____
In community - no program	_____
In institutions	_____

Signed _____

Please return within one week to:

Dr. Gail A. Harris
MARCA - Special Projects
510 Michigan National Tower
Lansing, Michigan 48933

APPENDIX B

Dear Friend of the Mentally Retarded in Michigan:

We are pleased to invite you to the third annual conference on Placement and Program Needs for the Mentally Retarded, sponsored by the Michigan Association for Retarded Children and Adults in cooperation with the Michigan Departments of Social Services, Mental Health, Public Health, Vocational Rehabilitation Services and Special Education. The conference will be held on Monday, March 11, 1974 at the Civic Center, 505 West Allegan, downtown Lansing. A program is enclosed.

The purpose of the conference is to further communication practices and cooperative arrangements between parents, professionals and agencies, in addition to making concrete recommendations for improved services for the mentally retarded in Michigan.

We highly encourage your participation at this important meeting.

A $2 registration fee will be collected at the door.

Please detach and return by March 1, 1974 to:

Michigan Association for Retarded Children and Adults
510 Michigan National Tower
Lansing, Michigan 48933

The following number of persons will attend the March 11, 1974 conference on Concerns in Placement for the Mentally Retarded.

_____# attending.

Signed _____

Agency _____

Address _____

"CONCERN, COMMUNICATION, COLLABORATION--THREE"

(Third Annual Conference on Placement and Programs for the Mentally Retarded)

Monday, March 11, 1974
9:00 A.M. to 3:00 P.M.
Lansing Civic Center

Sponsored by:
Michigan Association for Retarded Children and Adults
In Cooperation With:
Michigan Department of Social Services
Michigan Department of Mental Health
Michigan Department of Public Health
Division of Special Education
Vocational Rehabilitation Service

PROGRAM

9:00 A.M.	Registration and Coffee (Prudden Lounge)
9:30 A.M.	Welcome and Introduction of Speaker (Prudden Hall) --Dr. Edward Ruman, President, MARCA
	Mental Retardation Issues from the Super-Agency Perspective --Dr. John Dempsey, Director, State Department of Management and Budget
	Reactor Panel --State Senators, State Representatives, County Commissioners, Parents and State Agency Representatives from Mental Health, Vocational Rehabilitation, Social Services, Public Health and Special Education
	Moderator: Harvey D. Zuckerberg, Executive Director, MARCA
11:45 A.M.	Lunch (on your own; the registration desk will have a list of nearby facilities)
1:00 P.M.	Workshop Instructions (Prudden Hall) --Dr. Gail Harris, MARCA Twenty inter-disciplinary workshop sessions will be held for the purpose of pinpointing problems and suggesting practical solutions to help provide quality services to the retarded and developmentally disabled who are in state institutions or in community placements. Workshop leaders will include the Developmental Disabilities Advisory Council, state consultants and legislators.
2:30 P.M.	Summary (Prudden Hall)
3:00 P.M.	Adjournment

SUGGESTED ISSUES FOR WORKSHOP SESSIONS
(Group to develop practical solutions)

The group may wish to determine their own issues - or might select any from this list. Resource personnel are encouraged to select issues of interest to them.

In discussing issues regarding services, they should identify:

1) the current provision for the service
2) the problems
3) the possible solutions

DISCUSSION OF SOLUTIONS SHOULD INCLUDE THE POTENTIAL SUPER-AGENCY ORGANIZATION

Possible Issues

1. What should be done to improve Institution pre-release programming?
2. Should a state agency be responsible for epileptics in need of residential care?
3. How can institutions communicate better with parents?
4. How can health needs of institution residents be adequately met (i.e., physical and dental care, hearing aids, glasses, etc.)?
5. What would be an effective system of respite care?
6. What agency or other group should be responsible for a fixed point of referral (or life consultation center) in the community?
7. What steps can be taken to make the regional inter-agency committees more effective?
8. What suggestions for improved Cadre services can you make?
9. Should Developmental Disability funds be used to pay for a coordinator in each of the 19 inter-agency regions?
10. Should young adults be placed with geriatric patients in nursing homes? If so, under what circumstances?
11. What types of services should state institutions provide?
12. What improvements need to be made relative to the Michigan State Housing Development Authority provision of group homes for the retarded?

Possible Issues Continued

13. What additional services are needed for the retarded individual over 25 years of age?

14. Suggest major state concerns where position papers are needed.

15. What types of family supportive services are needed to prevent institutionalization?

16. What changes are needed in Act 54 programs?

17. What public relations measures should be undertaken to improve community services for the developmentally disabled?

18. What additional statewide preventive services are needed?

19. What agency(ies) should assume responsibility for evaluating at least the first year of a returned institution resident's program in the community?

20. Should specialized extended care be provided for those with epilepsy who are subject to frequent seizures? If so, what services should be included and who should administer this service?

21. What changes need to be made in Michigan's zoning laws?

22. What changes need to be made in Fire Marshal regulations?

23. How can we develop an efficient and effective system of transportation to community programs?

24. Should one agency (which one) assume major responsibility for public information?

APPENDIX C

TABLE A
SUMMARY
MENTALLY RETARDED RESIDENTS-BY INSTITUTION-BY AGE
12/31/73

	0-5	6-12	13-17	18-20	21-44	45-64	65+	Totals[2]
Alpine	4	12	22	8	82	15	1	138
Caro	3	78	148	112	481	144	21	988
Center for Human Devp.	17	96	202	96	478	121	16	1026
Coldwater	17	168	271	123	750	174	27	1530
Hillcrest	12	31	49	45	136	34	13	320
MACOMB-OAKLAND[1]	(33)	(103)	(72)	(39)	(	164)	-	(409)
Muskegon	14	46	66	38	92	4	1	261
Northville	-	13	34	19	75	28	1	170
Newberry	9	35	55	21	141	86	21	362
Oakdale	10	88	277	176	902	396	54	1903
Plymouth	26	192	317	221	288	9	-	1053
Wayne County	-	33	128	6	2	-	-	169
Totals	112	792	1569	865	3427	1011	155	7920[3]

[1]MACOMB-OAKLAND data is not included in totals computation, as all "residents" are serviced in community placements.

[2]There were 3 persons with unknown ages in state institutions as of 6/30/73. These persons were not specifically categorized in the 12/31/73 print outs made available.

[3]Total includes 220 males and 141 females that have invalid or unknown program codes. (Programmative total is 7,559.)

Source: Michigan Department of Mental Health, Reports number 49027-1 and 41021-1.

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TABLE B
SUMMARY
MENTALLY RETARDED INSTITUTION RESIDENTS - BY AGE, SEX AND PROGRAM
12/31/73

	0-5		6-12		13-17		18-20		21-44		45-64		65+		Totals		Grand Total
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Behavior Treatment	1	2	4	2	17	11	15	16	54	51	8	9			66	2	193
Phys. Handicapped	1	1	33	22	76	63	36	38	164	128	33	24	7	6	231	175	632
Habilitation	7	5	28	18	15	5	6	3	5	2					40	25	94
Blind	2	2	14	8	8	5	17	6	11	10					27	20	83
Deaf						7		8	2	1						20	17
Nursery-Toddler	5	2	20	10	10	8					1				52	29	57
Pre-School	2	2	3	2											4	3	9
Growth-Development	2	1	158	82	362	219	194	126	179	184	2	17	1		916	640	1527
Adult Activities		1		1	3	3	20	17	942	642	423	276	69	32	1537	1062	2423
Trainable/Educable			16	10	55	24	17	12	4	7		1			93	67	146
Trainable			12	6	65	16	45	22	15	33					205	119	214
Educable			26	5	53	19	16	16	13	19					124	61	167
Voc. Training				1	35	16	35	34	315	112	65	19	3		491	198	635
Infirmary	32	34	129	130	178	137	93	47	198	248	34	73	11	24	794	801	1362
Totals[1]	56	56	479	313	988	581	509	356	1942	1485	578	433	91	64			
Grand Totals[3]	112		792		1569		865		3427		1011		155				7920[2]

[1]The sums of the vertical columns may not equal the totals indicated as the Macomb-Oakland data is not included in Grand Totals. (all "residents" are served in community placement.) Programmatically identified total is 7,559. Totals include 220 males and 141 females that have invalid or unknown program codes.

[2]Horizontal Grand Total is actually 7,931-discrepancy unaccounted for in supplied data.

[3]Total includes persons with unknown ages. In 6/30/73 there were 3 such persons statewide.

Source: Michigan Department of Mental Health, Reports number 49027-1 and 41021-1.

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TABLE C
SUMMARY
MENTALLY RETARDED RESIDENTS-BY INSTITUTION-BY PROGRAM
12/31/73

	Behavior Trtmt	Phys Hand	Habili tation	Blind	Deaf	Nursery Toddler	Pre School	Growth & Devp	Adult Act	Trnable/ Educable	Train-able	Educa-able	Voc Trng.	Infirm	Totals[1]
Alpine														125	138
Caro	4	1				20		124	342	9	118	27	97	226	988
Center for Human Devp.	1	167		1		5		193	418	-	2	1	26	196	1026
Coldwater	65	141					6	218	538	137		1	186	219	1530
Hillcrest	4	55						48	31					144	320
Muskegon		15	11			11	3	93	54			7	63		261
Northville								85	84						170
Newberry	50	52						40	134		45	5		36	362
Oakdale	44	20			17	21		352	819		53	126	158	234	1903
Plymouth	25	18	83	82				374	3				106	182	1053
Wayne Co.											1				169
Totals[1]	193	632	94	83	17	57	9	1527	2423	146	214	167	635	1362	7920[2]

[1] The sums of the columns may not equal the totals indicated as the totals include 220 males and 141 females that have invalid or unknown program codes. Programmatically identified total is 7,559.

[2] Total includes persons with unknown ages. In 6/30/73 there were 3 such persons statewide.

Source: Michigan Department of Mental Health, Reports #49027-1 and 41021-1.

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TABLE D

HANDICAPPING CONDITIONS
12/31/73

INSTITUTION	VISUAL IMPAIRMENT	HEARING IMPAIRMENT	SPEECH AND LANGUAGE IMPAIRMENT	CONVULSIVE DISORDER	MOTOR IMPAIRMENT	TOTAL
Caro	73	40	16	92	12	238
Coldwater	209	103	74	360	22	768
Alpine	8	2	2	21	3	36
Hillcrest	26	23	9	81	7	146
Oakdale	107	117	23	225	2	474
Center for Human Development	94	30	38	276	8	446
Muskegon	16	9	4	48	2	79
Newberry	79	32	18	96	5	230
Northville-MR	6	10	3	22	0	41
Plymouth	234	69	243	267	77	890
Wayne County	0	0	1	0	0	1
Totals[1]	357	435	430	1488	138	3348

[1]Any patient may fall into more than one category. Bottom total does not reflect total patients.

Source: Michigan Department of Mental Health, Report number 41037-1

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TABLE E
SUMMARY
PERSONNEL - STATE INSTITUTIONS FOR MENTALLY RETARDED
6/30/73

	CARO	COLDWATER	GAYLORD	HOWELL	LAPEER	MACOMB	MT PLEASANT	MUSKEGON	NORTHVILLE	PLYMOUTH	TOTAL
Administrative & Office Personnel	52	80	15	26	101	6	47	17	13	30	437
Community Representatives, Volunteer Coordinators	1	1	0	1	2	1	0	0	0	1	7
Dentists	1	2	0	1	3	0	1	1	0	2	11
Dental Aides	1	2	0	0	1	0	1	1	0	2	8
Dieticians	0	0	0	0	0	0	0	0	0	1	1
Educators	1	12	0	0	5	0	9	0	1	9	37
Maintenance (1)	58	71	16	24	67	1	36	13	0	46	332
Medical Doctors											
Psychiatrists	1	0	0	0	0	0	0	0	0	0	1
Psychiatric Residents	0	0	0	0	0	0	0	0	0	0	0
Other Medical	4	8	2	3	10	0	5	1	1	5	39
Medical Superintendents	0	1	1	1	0	0	0	0	0	0	3
Non-Medical Superintendents	1	0	0	0	1	1	0	1	1	1	6
Nursing Personnel											
Child Care	4	0	7	2	2	0	3	0	0	5	23
General Services	442	662	73	152	648	0	438	115	90	529	3149
Licensed Practical Nurses	8	22	4	8	33	0	45	8	4	32	164
Registered Nurses	29	24	14	16	24	0	23	11	13	28	182
Pharmacists	1	2	0	1	3	0	2	0	0	1	10
Program Administrators	4	5	1	3	16	1	4	5	5	9	53
Psychologists	3	4	1	0	4	0	5	1	0	5	23
Psychologist Trainees	0	0	0	0	0	0	0	0	0	0	0

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TABLE E CONTINUED

	CARO	COLDWATER	GAYLORD	HOWELL	LAPEER	MACOMB	MT PLEASANT	MUSKEGON	NORTHVILLE	PLYMOUTH	TOTAL
Rehabilitation and Patient Services	11	57	2	5	21	0	14	2	15	14	141
Social Workers	6	11	0	4	8	4	6	4	2	21	66
Social Work Trainees	0	0	0	0	0	1	0	1	0	0	2
Technicians & Specialists	2	6	1	2	6	0	5	1	0	6	29
Tech.-Spec. Assistants	1	0	0	0	0	0	0	0	0	0	1
Therapists											
Arts & Crafts Instructors	4	1	1	0	5	0	0	1	4	1	17
Industrial Therapists	0	1	0	0	0	0	0	0	0	1	2
Music Therapists/Directors	1	0	0	0	0	0	0	0	0	1	2
Occupational Therapists	0	0	0	1	3	2	0	0	0	4	10
Physical Therapists	0	1	1	0	1	0	0	1	0	2	6
Recreational Therapists	7	3	2	9	10	2	4	1	12	13	63
Speech Therapists/Audiologists	3	3	0	1	2	1	2	2	0	4	18
Other Therapists, Aides	1	2	0	0	4	0	3	0	2	3	15
Therapist Trainee	0	2	0	0	2	0	2	1	1	2	10
Trainees (Other)	4	7	0	1	53	1	47	21	0	8	142
All Other Employees	11	9	0	3	14	0	4	0	2	18	61
Total Employees	885	1194	167	334	1275	21	821	231	178	974	6080

[1]Includes Carpenters, Plumbers, Electricians, Groundskeepers, Safety Officers, Construction Equipment Operators.

Source: Michigan Department of Mental Health, Report #13547-6

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ITEM F

May 11, 1973

TO: James Rosenfeld

FROM: Joseph C. Denniston, M.D.
Deputy Director

SUBJECT: Denniston's Rule 234 regarding any community placement

2. a. Is the proposed placement in the best interest of the indivdual?
   b. Is it equal to or better than the current placement?

3. a. Does the individual desire or agree to the placement?
   b. Do the parents desire or agree to the placement?
   c. Does the operator of the placement facility desire the individual?

4. a. Does the proposed placement facility meet acceptable licensure standards?
   b. Will there be a written individualized meaningful program for the individual and are there adequate community resources.
   c. Will the physical plant and the program be so monitored as to assure that the placement is proper, adequate and appropriate.
   d. Will there be an advocacy component established to protect the rights, the worth, the dignity and the value of the individual?

JOD/d

cc. Dr. Yudashkin
Mr. Crosby
Mr. Heller

APPENDIX D

MICHIGAN ASSOCIATION FOR RETARDED CHILDREN AND ADULTS
SPECIAL PROJECTS
510 Michigan National Tower
Lansing, Michigan 48933
Telephone (517) 485-2647

M E M O

TO: Dr. Maurice Reizen, Michigan Department of Public Health
Mr. Bernard Houston, Michigan Department of Social Services
Dr. Gordon Yudashkin, Michigan Department of Mental Health
Dr. John Porter, Michigan Department of Education
Mr. Murray Batten, Michigan Department of Education
Dr. Don Galvan, Michigan Department of Education
Mr. Harvey Zuckerberg, MARCA
Mr. Tom Caughlin, Epilepsy Center of Michigan
Mr. Roy Morrison, Michigan UCPA

FROM: Dr. Gail A. Harris, Project Director
Mr. Paul Tobey, Developmental Disabilities Coordinator

DATE: April 15, 1974

RE: Meeting - Thursday, May 16, 1974, 1:00 p.m., Stoddard Building, Lansing, Michigan

We are inviting you to participate in a meeting on Thursday, May 16, 1974 from 1:00 p.m. to 4:30 p.m. in the Stoddard Building, 4th floor Conference Room (corner of Capitol and Allegan in Lansing).

As you know, Dr. Harris has been directing a project to develop a state action plan to:

a) improve community services for the developmentally disabled and to
b) improve institution services for this group.

The state Cadre has served in an Advisory capacity to the project.

Before the meeting, you and the Cadre members will be sent an abstract of specific proposed project recommendations which are proposed for the state plan. They are for your consideration before the meeting.

At the meeting, you will be asked to respond to the proposed recommendations with approval, rejection or revisions and with agency commitments to action.

It is highly important that you plan to attend. Please contact Dr. Harris if you have any questions before the meeting. (Phone 485-2647)

MICHIGAN ASSOCIATION FOR RETARDED CHILDREN AND ADULTS
SPECIAL PROJECTS
510 Michigan National Tower
Lansing, Michigan 48933
Telephone (517) 485-2647

M E M O

TO: Dr. Maurice Reizen, Michigan Department of Public Health
Mr. Bernard Houston, Michigan Department of Social Services
Dr. Gordon Yudashkin, Michigan Department of Mental Health
Dr. John Porter, Michigan Department of Education
Mr. Murray Batten, Michigan Department of Education
Dr. Don Galvan, Michigan Department of Education
Mr. Harvey Zuckerberg, MARCA
Mr. Tom Caughlin, Epilepsy Center of Michigan
Mr. Roy Morrison, Michigan UCPA

FROM: Dr. Gail A. Harris, Project Director
Mr. Paul Tobey, Developmental Disabilities Coordinator

DATE: May 6, 1974

RE: Meeting - Thursday, May 16, 1974, 1:00 p.m., Stoddard Building, Lansing, Michigan

This is a follow-up to our April 15, 1974 memo to you asking you to participate in a meeting on Thursday, May 16, 1974 from 1:00 p.m. to 4:30 p.m. in the Stoddard Building, 4th Floor Conference Room (corner of Capitol and Allegan in Lansing).

The Cadre has reviewed the abstracted recommendations and we are now sending the recommendations to you and the Cadre members which will be considered on May 16.

For your background information, we are also sending to you a report of the recommendations from the March 11, 1974 Interagency Conference at the Lansing Civic Center and a summary of the recommendations from the Regional Interagency Committees surveys.

At the meeting on May 16, you will be asked to respond to the proposed recommendations with approval, rejection or revisions and with agency commitments to action. You will be asked to assist us then or later with a proposed time-line which will be practical for implementation of the recommendations.

It is highly important that you plan to attend this meeting inasmuch as the results of the meeting will be incorporated in this section of the State Plan for Services to the Developmentally Disabled.

Please contact Dr. Harris if you have any questions before the meeting. (Telephone 485-2647)

GAH:PT/em

Enclosures

MICHIGAN ASSOCIATION FOR RETARDED CHILDREN AND ADULTS
SPECIAL PROJECTS
510 Michigan National Tower
Lansing, Michigan 48933

Meeting of Agency Heads

May 16, 1974 - 1:00 p.m.

A G E N D A

Introductions, Purpose of Project	Mr. Tobey
Project Procedures, Purpose of Meeting ,	Dr. Harris
Proposed Coordination Framework	Mrs. Miller
Organization Chart	Dr. Harris
Reactions to Principles and Recommendations	Agency Heads
Time Line	Dr. Harris
Endorsements	Mr. Tobey
Next Steps (Potential Implementation Funds)	